DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.310 Review Procedure

a) Inpatient Rate Reviews

1) Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of any rate for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) Hospitals reimbursed in accordance with Sections 148.250 through 148.300 and 89 Ill. Adm. Code 149 with respect to per diem add-ons for capital may request that an adjustment be made to their base year costs to reflect significant changes in costs that have been mandated in order to meet State, federal or local health and safety standards, and that have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be submitted, in writing, to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

b) Disproportionate Share (DSH) and Medicaid Percentage Adjustment (MPA) Determination Reviews

1) Hospitals shall be notified of their qualification for DSH and/or MPA payment adjustments and shall have an opportunity to request a review of the DSH and/or MPA add-on for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be

received or post marked within 30 days after the date of the Department's notice to the hospital of its disproportionate share and/or Medicaid Percentage Adjustment qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) DSH and/or MPA determination reviews shall be limited to the following:

A) DSH and/or MPA Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. The criteria for MPA determination shall be in accordance with Section 148.122. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.

B) Medicaid Inpatient Utilization Rates.

i) Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(4). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

ii) Hospitals' Medicaid inpatient utilization rates, as defined in Section 148.120(k)(4), which have been derived from unaudited cost reports or HDSC forms, are not subject to the Review Procedure with the exception of errors in calculation by the Department. Pursuant to Section 148.120(c)(1)(B) and (c)(1)(C)(i) and (ii), hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH and/or MPA determination.

C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act, Section 148.120(a)(2) and (d), and Section 148.122(a)(2) and (c). Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.

D) Federally Designated Health Manpower Shortage Areas (HMSAs). Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5 (1989) and Section 148.122(a)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the federal Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally-designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of June 30, 1992.

E) Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 (Section 148.122(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.

F) Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Section 148.122(a)(4), (h)(2), (h)(3) and (h)(4). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.

c) Outlier Adjustment Reviews

The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 or Section 148.130, whichever is applicable. Hospitals shall be notified of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of the specific information that shall be utilized in

the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

d) Cost Report Reviews

1) Cost reports are required from:

A) All enrolled hospitals within the State of Illinois;

B) All out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and

C) All hospitals not located in Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG PPS).

2) The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days after the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis that support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

e) Trauma Center Adjustment Reviews

1) The Department shall make trauma care adjustments in accordance with Section 148.290(c). Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation by the Department.

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

3) Appeals under this subsection (e) must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

f) Medicaid High Volume Adjustment Reviews
The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(d). Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with Section 148.120. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

g) Sole Community Hospital Designation Reviews
The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the

designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

h) Geographic Designation Reviews

1) The Department shall make rural hospital designations in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

2) The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

i) Critical Hospital Adjustment Payment (CHAP) Reviews

1) The Department shall make CHAP in accordance with Section 148.295. Hospitals shall be notified in writing of the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if the hospital believes that a

technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for CHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the CHAP. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) CHAP determination reviews shall be limited to the following:

A) Federally Designated Health Professional Shortage Areas (HPSAs). Illinois hospitals located in federally designated HPSAs shall be identified in accordance with 42 CFR 5, and Section 148.295(a)(3)(B) and (b)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the federal Department of Health and Human Services as of the last day of June preceding the CHAP rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of the last day of June preceding the CHAP rate period.

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

C) Accreditation of Rehabilitation Facilities. Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating

that the information supplied to and utilized by the Department was incorrect.

D) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

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

j) Tertiary Care Adjustment Payment Reviews. The Department shall make Tertiary Care Adjustment Payments in accordance with Section 148.296. Hospitals shall be notified in writing of the results of the Tertiary Care Adjustment Payments determination and calculation, and shall have the right to appeal the Tertiary Care Adjustment Payments calculation or their ineligibility for Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

k) Pediatric Outpatient Adjustment Payment Reviews. The Department shall make Pediatric Outpatient Adjustment payments in accordance with Section 148.297. Hospitals shall be notified in writing of the results of the determination and

calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.297 if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.297 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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

m) Safety Net Adjustment Payment Reviews. The Department shall make Safety Net Adjustment Payments in accordance with Section 148.126. Hospitals shall be notified in writing of the results of the Safety Net Adjustment Payment determination and calculation, and shall have the right to appeal the Safety Net Adjustment Payment calculation or their ineligibility for Safety Net Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Safety Net Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Safety Net Adjustment Payments. Such a

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

n) Psychiatric Adjustment Payment Reviews. The Department shall make Psychiatric Adjustment Payments in accordance with Section 148.105. Hospitals shall be notified in writing of the results of the Psychiatric Adjustment Payments determination and calculation, and shall have a right to appeal the Psychiatric Adjustment Payments calculation or their ineligibility for Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

o) Rural Adjustment Payment Reviews. The Department shall make Rural Adjustment Payments in accordance with Section 148.115.

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

2) The designation of Critical Access Provider or Necessary Provider, which are qualifying criteria for Rural Adjustment Payments (see Section 148.115(a)), is obtained from the Illinois Department of Public Health (IDPH) as of the first day of July preceding the Rural Adjustment Payment rate period. Review shall be limited to requests accompanied by documentation from IDPH, substantiating that the information supplied to and utilized by the Department was incorrect.

3) The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rural Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

p) Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with Section 148.85. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

q) Medicaid Inpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Inpatient Utilization Rate Adjustment Payments in accordance with Section 148.90. Hospitals shall be notified in writing of the results of the Medicaid Inpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Inpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Inpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Inpatient Utilization Rate

Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Inpatient Utilization Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

r) Medicaid Outpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Outpatient Utilization Rate Adjustment Payments in accordance with Section 148.95. Hospitals shall be notified in writing of the results of the Medicaid Outpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Outpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Outpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Outpatient Utilization Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Outpatient Utilization Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

s) Outpatient Rural Hospital Adjustment Payment Reviews. The Department shall make Outpatient Rural Adjustment Payments in accordance with Section 148.100. Hospitals shall be notified in writing of the results of the Outpatient Rural Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Rural Adjustment Payments calculation or their ineligibility for Outpatient Rural Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Rural Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the

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

t) Outpatient Service Adjustment Payment Reviews. The Department shall make Outpatient Service Adjustment Payments in accordance with Section 148.103. Hospitals shall be notified in writing of the results of the Outpatient Service Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Service Adjustment Payments calculation or their ineligibility for Outpatient Service Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Service Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Service Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

u) Psychiatric Base Rate Adjustment Payment Reviews. The Department shall make Psychiatric Base Rate Adjustment Payments in accordance with Section 148.110. Hospitals shall be notified in writing of the results of the Psychiatric Base Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Psychiatric Base Rate Adjustment Payments calculation or their ineligibility for Psychiatric Base Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Base Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Base Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

v) High Volume Adjustment Payment Reviews. The Department shall make High Volume Adjustment Payments in accordance with Section 148.112. Hospitals shall be notified in writing of the results of the High Volume Adjustment Payments

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

w) Medicaid Eligibility Payment Reviews. The Department shall make Medicaid Eligibility Payments in accordance with Section 148.402. Hospitals shall be notified in writing of the results of the Medicaid Eligibility Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Eligibility Payments calculation or their ineligibility for Medicaid Eligibility Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Eligibility Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Eligibility 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.

x) Medicaid High Volume Adjustment Payment Reviews. The Department shall make Medicaid High Volume Payments in accordance with Section 148.404. Hospitals shall be notified in writing of the results of the Medicaid High Volume Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid High Volume Payments calculation or their ineligibility for Medicaid High Volume Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid High Volume Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid High Volume Adjustment Payments.

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

y) Intensive Care Adjustment Payment Reviews. The Department shall make Intensive Care Payments in accordance with Section 148.406. Hospitals shall be notified in writing of the results of the Intensive Care Payments determination and calculation. Hospitals shall have a right to appeal the Intensive Care Payments calculation or their ineligibility for Intensive Care Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Intensive Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Intensive Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

z) Trauma Center Adjustment Payment Reviews. The Department shall make Trauma Center Adjustment Payments in accordance with Section 148.408. Hospitals shall be notified in writing of the results of the Trauma Center Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Trauma Center Adjustment Payments calculation or their ineligibility for Trauma Center Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Trauma Center Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Trauma Center Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

aa) Psychiatric Rate Adjustment Payment Reviews. The Department shall make Psychiatric Rate Adjustment Payments in accordance with Section 148.410. Hospitals shall be notified in writing of the results of the Psychiatric Rate

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

bb) Rehabilitation Adjustment Payment Reviews. The Department shall make Rehabilitation Adjustment Payments in accordance with Section 148.412. Hospitals shall be notified in writing of the results of the Rehabilitation Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Adjustment Payments calculation or their ineligibility for Rehabilitation Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

cc) Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with Section 148.414. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the

Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

dd) Crossover Percentage Adjustment Payment Reviews. The Department shall make Crossover Percentage Adjustment Payments in accordance with Section 148.416. Hospitals shall be notified in writing of the results of the Crossover Percentage Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Crossover Percentage Adjustment Payments calculation or their ineligibility for Crossover Percentage Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Crossover Percentage Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Crossover Percentage Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

ee) Long Term Acute Care Hospital Adjustment Payment Reviews. The Department shall make Long Term Acute Care Hospital Adjustment Payments in accordance with Section 148.418. Hospitals shall be notified in writing of the results of the Long Term Acute Care Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Long Term Acute Care Hospital Adjustment Payments calculation or their ineligibility for Long Term Acute Care Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Long Term Acute Care Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Long Term Acute Care Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The

Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

ff) Obstetrical Care Adjustment Payment Reviews. The Department shall make Obstetrical Care Adjustment Payments in accordance with Section 148.420. Hospitals shall be notified in writing of the results of the Obstetrical Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Obstetrical Care Adjustment Payments calculation or their ineligibility for Obstetrical Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Obstetrical Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Obstetrical Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

gg) Outpatient Access Payment Reviews. The Department shall make Outpatient Access Payments in accordance with Section 148.422. Hospitals shall be notified in writing of the results of the Outpatient Access Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Access Payments calculation or their ineligibility for Outpatient Access Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Access Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Access 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.

hh) Outpatient Utilization Payment Reviews. The Department shall make Outpatient Utilization Payments in accordance with Section 148.424. Hospitals shall be notified in writing of the results of the Outpatient Utilization Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Utilization

Payments calculation or their ineligibility for Outpatient Utilization Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Utilization Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Utilization 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.

ii) Outpatient Complexity of Care Adjustment Payment Reviews. The Department shall make Outpatient Complexity of Care Adjustment Payments in accordance with Section 148.426. Hospitals shall be notified in writing of the results of the Outpatient Complexity of Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Complexity of Care Adjustment Payments calculation or their ineligibility for Outpatient Complexity of Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Complexity of Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Complexity of Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

jj) Rehabilitation Hospital Adjustment Payment Reviews. The Department shall make Rehabilitation Hospital Adjustment Payments in accordance with Section 148.428. Hospitals shall be notified in writing of the results of the Rehabilitation Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Hospital Adjustment Payments calculation or their ineligibility for Rehabilitation Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Hospital Adjustment Payments and payment

adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

kk) Perinatal Outpatient Adjustment Payment Reviews. The Department shall make Perinatal Outpatient Adjustment Payments in accordance with Section 148.430. Hospitals shall be notified in writing of the results of the Perinatal Outpatient Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Perinatal Outpatient Adjustment Payments calculation or their ineligibility for Perinatal Outpatient Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Perinatal Outpatient Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Perinatal Outpatient Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

ll) Supplemental Psychiatric Adjustment Payment Reviews. The Department shall make Supplemental Psychiatric Adjustment Payments in accordance with Section 148.432. Hospitals shall be notified in writing of the results of the Supplemental Psychiatric Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Psychiatric Adjustment Payments calculation or their ineligibility for Supplemental Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Psychiatric Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

mm) Outpatient Community Access Adjustment Payment Reviews. The Department shall make Outpatient Community Access Adjustment Payments in accordance with Section 148.434. Hospitals shall be notified in writing of the results of the Outpatient Community Access Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Community Access Adjustment Payments calculation or their ineligibility for Outpatient Community Access Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Community Access Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Community Access Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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

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

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

Section 148.402 Medicaid Eligibility Payments

a) Qualifying Criteria. Medicaid Eligibility Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it was assessed as described in 89 Ill. Adm. Code 140.80 for the rate year 2006 determination.

b) The following classes of hospitals are ineligible for Medicaid Eligibility Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

c) Medicaid Eligibility Payments

1) A hospital qualifying under subsection (a) of this Section shall receive payment equal to the product of $430.00 multiplied by the qualifying hospital's Medicaid admissions in the Medicaid eligibility base year multiplied by the growth percentage of Medicaid clients within the hospital's county from State fiscal year 1998 to State fiscal year 2003.

2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being preformed under this subsection.

d) Payment to a Qualifying Hospital

1) For the Medicaid eligibility adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

1) "Growth percentage" means, for a given hospital, the percentage of change in the growth of Medicaid clients within the county where the hospital is located from 1998 to 2003.

2) "Medicaid admissions" means, for a given hospital, the sum of admissions of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the Medicaid eligibility base period that were adjudicated by the Department through June 30, 2004.

3) "Medicaid eligibility adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

4) "Medicaid eligibility base period" means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.404 Medicaid High Volume Adjustment Payments

a) Qualifying Criteria. Medicaid High Volume Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it is:

1) an Illinois hospital that did not qualify for Medicaid Percentage Adjustments as described in Section 148.122 for the 12-month period beginning on October 1, 2004 and provided more than 10,000 Medicaid inpatient days in the Medicaid high volume base period; or

2) an Illinois general acute care hospital as defined in Section 148.270(c)(1) that did qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning on October 1, 2004 and provided more than 21,000 Medicaid inpatient days in the Medicaid high volume base period.

b) The following classes of hospitals are ineligible for high volume adjustment payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

c) Medicaid High Volume Adjustment Payments

1) For a hospital qualifying under subsection (a)(1) of this Section, payment is as follows:

A) A hospital that:

i) provided less than or equal to 14,500, but more than 10,000 Medicaid inpatient days in the Medicaid high volume base period, shall receive payments equal to the product of

$90.00 multiplied by the qualifying hospital's Medicaid inpatient days;

ii) provided less than or equal to 18,500, but more than 14,500 Medicaid inpatient days in the Medicaid high volume base period, shall receive payments equal to the product of $135.00 multiplied by the qualifying hospital's Medicaid inpatient days;

iii) provided less than or equal to 20,000, but more than 18,500 Medicaid inpatient days in the Medicaid high volume base period, shall receive payments equal to the product of $225.00 multiplied by the qualifying hospital's Medicaid inpatient days, or

iv) provided 20,000 or more Medicaid inpatient days in the Medicaid high volume base period, shall receive payments equal to the product of $900.00 multiplied by the qualifying hospital's Medicaid inpatient days.

B) Payments will be the lesser of the calculation described in subsection (c)(1)(A)(i), (c)(1)(A)(ii), (c)(1)(A)(iii), and (c)(1)(A)(iv) or $19 million dollars.

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

A) Payment equal to the product of $35.00 multiplied by the qualifying hospital's Medicaid inpatient days.

B) Payments will be the lesser of the calculation described in subsection (c)(2)(A) or $1,200,000.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being preformed under this subsection.

d) Payment to a Qualifying Hospital

1) For the Medicaid high volume adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

1) "Medicaid high volume adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

2) "Medicaid high volume base period" means the cost report as on file with the Department on July 1, 2004, for the hospital's fiscal year ending in 2002.

3) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained on the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.406 Intensive Care Adjustment Payments

a) Qualifying Criteria. Intensive Care Adjustment Payments shall be made to qualifying Illinois general acute care hospitals as described in Section 148.270(c)(1). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if the hospital is located in a large urban area and has a ratio of Medicaid intensive care days to total Medicaid days greater than 19 percent for the intensive care adjustment period.

b) The following classes of hospitals are ineligible for Intensive Care Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

c) Intensive Care Adjustment Payments

1) Each qualifying hospital with an intensive care ratio of less than 30 percent, shall receive payment equal to the product of:

A) The ratio of Medicaid intensive care days to total Medicaid days;

B) Multiplied by total Medicaid days;

C) Multiplied by $1,000.

2) Each qualifying hospital with an intensive care ratio percentage greater than 30 percent, shall receive payment equal to the product of the:

A) Ratio of Medicaid intensive care days to total Medicaid days;

B) Multiplied by total Medicaid days;

C) Multiplied by $2,800.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the intensive care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days hospital was open during the fiscal year.

e) Definitions

1) "Intensive care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

2) "Intensive care base period" means the cost report as on file with the Department on July 1, 2004, for the hospital's fiscal year ending in 2002.

3) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and is an urban hospital as described in Section 148.25(g)(4).

4) "Medicaid intensive care days" means, for a given hospital, the sum of days of inpatient hospital service for intensive care days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained on the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

5) "Total Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained on the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.408 Trauma Center Adjustment Payments

a) Qualifying Criteria. Trauma Center Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it was a general acute care hospital that, as of January 1, 2005 was considered a trauma center and meets the requirements specified in subsection (c).

b) The following classes of hospitals are ineligible for Trauma Center Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a Sate agency, as described in Section 148.25(b)(6).

c) Trauma Center Adjustment Payments

1) Level I Trauma Center Adjustment Payments

A) For an Illinois general acute care hospital that was considered a Level I trauma center as of January 1, 2005, that is located in a large urban area or other urban area that qualifies for Medicaid Percentage Adjustments as described in Section 148.122 as of October 1, 2004, shall receive payments equal to the product of $800.00 multiplied by the qualifying hospital's Medicaid ICU days in the trauma base period.

i) For a hospital located in a large urban area outside of a city with a population in excess of one million people, the Department shall pay an amount equal to the Level I Trauma Center Adjustment Payment calculated in subsection (c)(1)(A) of this Section multiplied by 4.5.

ii) For a hospital located in an other urban area, the Department shall pay an amount equal to the Level I

Trauma Center Adjustment Payment calculated in (c)(1)(A) multiplied by 8.5.

2) Level II Trauma Center Adjustment Payments

A) For an Illinois general acute care hospital that was considered a Level II trauma center as of January 1, 2005 and is located in a county with a population in excess of three million people, the payment shall equal:

i) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid $4,000.00 per day for the first 500 Medicaid inpatient days in the trauma base period.

ii) A hospital qualifying under subsection (c)(2)(A) of this Section shall be paid $2,000.00 per day for the Medicaid inpatient days between 501 and 1,500 in the trauma base period.

iii) For a hospital qualifying under subsection (c)(2)(A) of this Section shall be paid $100.00 per day for each Medicaid inpatient day over 1,500 in the trauma base period.

B) For an Illinois general acute care hospital that was considered a Level II trauma center as of January 1, 2005, and is located in a large urban area outside of a county with a population in excess of three million people and, as of January 1, 2005, was designated a Level III perinatal center or designated a Level II or II+ perinatal center that has a ratio of Medicaid intensive care unit days to total Medicaid days greater than five percent, the payment shall equal:

i) A hospital qualifying under subsection (c)(2)(B) of this Section shall be paid $4,000.00 per day for the first 500 Medicaid inpatient days in the trauma base period.

ii) A hospital qualifying under subsection (c)(2)(B) of this Section shall be paid $2,000.00 per day for the Medicaid

inpatient days between 501 and 1,500 in the trauma base period.

iii) For a hospital qualifying under subsection (c)(2)(B) of this Section shall be paid $100.00 per day for each Medicaid inpatient day over 1,500 in the trauma base period.

3) Pediatric Trauma Center Adjustment Payments

A) Qualifying Criteria: Payment shall be for all Illinois children's hospitals designated as Level I pediatric trauma centers that provided more than 30,000 Medicaid days in State fiscal year 2003 and those out-of-state Level I Pediatric trauma centers that provided more than 700 Illinois Medicaid admissions in State fiscal year 2003.

B) A hospital qualifying under subsection (c)(3)(A) under this Section shall receive payment equal to the product of $325.00 multiplied by the hospital's Illinois Medicaid intensive care unit days.

C) For out-of-state hospitals qualifying under subsection (c)(3)(A) the amount calculated under subsection (c)(3)(B) shall be multiplied by 2.25.

4) A hospital that enrolled to provide Medicaid services during fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

5) Notwithstanding any other provisions of this subsection, a children's hospital as defined at 89 Ill. Adm. Code 149.49(c)(3)(b), is not eligible for the payments described in subsections (c)(1) and (c)(2) of this Section.

d) Payment to a Qualifying Hospital

1) For the trauma center adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital

in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) being met shall be paid within 100 days after the conditions described in subsection (f) of this Section have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

1) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and is an urban hospital as described in Section 148.25(g)(4).

2) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained on the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

3) "Medicaid intensive care unit days" means, for a given hospital, the numbers of hospital inpatient days during which Medicaid recipients received intensive care services from the hospital, as determined from the hospital's 2002 Medicaid cost report on file with the Department on July 1, 2004.

4) "Other urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a city with a population in excess of 50,000 or a total population in excess of 100,000, and is an urban hospital as described in Section 148.25(g)(4).

5) "Trauma center adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006 and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

6) "Trauma center base period" means days reported on the hospital's 2002 Medicaid cost report on file with the Department on July 1, 2004.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.410 Psychiatric Rate Adjustment Payments

a) Qualifying Criteria: Psychiatric Rate Adjustment Payments described in subsection (b) of this Section shall be made to an Illinois psychiatric hospital and general acute care hospital that has a distinct part psychiatric unit, excluding the following hospitals:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Psychiatric Rate Adjustment Payments

1) For a hospital qualifying under subsection (a) of this Section, the Department shall pay an amount equal to $420.00 less the hospital's per diem rate for Medicaid inpatient psychiatric services, in effect on July 1, 2002, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period. In no event, however, shall that amount be less than zero.

2) For a hospital qualifying under subsection (a) of this Section whose inpatient psychiatric per diem rate is greater than $420.00, the Department shall pay an amount equal to $40.00 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.

3) For an Illinois psychiatric hospital located in a county with a population in excess of three million people that did not qualify for Medicaid Percentage Adjustments, as described Section 148.122, for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to $150.00 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.

4) For an Illinois psychiatric hospital located in a county with a population in excess of three million people, but outside of a city with a population in excess of one million people, and did qualify for Medicaid Percentage Adjustments, as described in Section 148.122, for the 12-month period beginning period on October 1, 2004, the Department shall pay an amount equal to $20.00 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric rate base period.

c) Payment to a Qualifying Hospital

1) For the psychiatric rate adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based n the number of days the hospital was open during the fiscal year.

d) Definitions

1) "Medicaid inpatient psychiatric days" means, for a given hospital, the sum of days of inpatient psychiatric hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the psychiatric base period that were adjudicated by the Department through June 30, 2004.

2) "Psychiatric rate adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Psychiatric rate base period" means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.412 Rehabilitation Adjustment Payments

a) Qualifying criteria. Rehabilitation Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment:

1) if it is an Illinois general acute-care hospital, as described in Section 148.270(c)(1), located in a large urban area, with a rehabilitation unit that has 40 rehabilitation beds or more based upon the 2003 Medicaid cost report on file with the Department as of March 31, 2005; or

2) if it is an Illinois rehabilitation hospital, as defined at 89 Ill. Adm. Code 149.50(c)(2), that did not qualify for Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004.

b) The following classes of hospitals are ineligible for Rehabilitation Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

c) Rehabilitation Adjustment Payments

1) For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay the product of $230.00 multiplied by the hospital's Medicaid inpatient days.

2) For a hospital qualifying under subsection (a)(2) of this Section, the Department shall pay an amount equal to the product of $200.00 multiplied by the hospital's Medicaid inpatient days.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the rehabilitation adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

1) "Large urban area" means, an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and is an urban hospital as described in Section 148.25(g)(4).

2) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the rehabilitation base period that was adjudicated by the Department through June 30, 2004.

3) "Rehabilitation adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006 and beginning July 1, 2006; the 12-month period beginning July 1 of the year and ending June 30 of the following year.

4) "Rehabilitation base period" means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.414 Supplemental Tertiary Care Adjustment Payments

a) Qualifying criteria: Supplemental Tertiary Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to all qualifying hospitals. An Illinois hospital shall qualify for payment if it was deemed eligible for payments under the Tertiary Care Adjustment Payments for fiscal year 2005, as described in Section 148.296, excluding;

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Supplemental Tertiary Care Adjustment Payments will be made to qualifying hospitals and will equal the product of the hospitals fiscal year 2005 tertiary care adjustment as described at Section 148.296 multiplied by 2.5.

c) Payment to a Qualifying Hospital

1) For the supplemental tertiary care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid

to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) "Tertiary care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006 means the 12-month period beginning July 1 of the year and ending June 30 of the following year.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.416 Crossover Percentage Adjustment Payments

a) Qualifying Criteria. Crossover Percentage Adjustment Payments shall be made to qualifying hospitals as defined in this subsection (a) of this Section. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it is a general acute care hospital, excluding any hospital defined as a cancer center hospital, as described in Section 148.270(c)(1), located in an urban area, that provided over 500 days of inpatient care to Medicaid recipients, that had a ratio of crossover days to total Medicaid days utilizing information used for the Medicaid percentage adjustment determination described in Section 148.122, effective October 1, 2004 of greater than 40 percent and that does not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122, on

October 1, 2004.

b) The following classes of hospitals are ineligible for Crossover Percentage Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

4) Cancer center hospitals.

c) Crossover Percentage Adjustment Payments

1) Each qualifying hospital's crossover days will be divided by their total Medicaid days for the crossover percentage ratio.

2) Each hospital qualifying under subsection (a) of this Section, located in an other urban area as described in subsection (e)(5) of this Section shall receive payment equal to $140.00 multiplied by the hospital's total Medicaid days including Medicaid/Medicare crossovers.

3) Each hospital qualifying under subsection (a) of this Section located in a large urban area as described in subsection (e)(4) of this Section, with a crossover percentage less than 55 percent, shall receive payment equal to $350.00 multiplied by the hospital's total Medicaid days including Medicaid/Medicare crossovers.

4) Each hospital qualifying under subsection (a) located in a large urban hospital as described in subsection (e)(4) of this Section, with a crossover percentage ratio equal to or greater than 55 percent, shall receive payment equal to $1,400.00 multiplied by the hospital's total Medicaid days including Medicaid/Medicare crossovers.

5) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the crossover percentage adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

1) "Cancer center hospital" means an Illinois hospital that has received the approval of the American College of Surgeons Commission on Cancer as of June 16, 2005 and provides more than 15 percent of the hospital Medicaid days in State fiscal year 2003 for treating patients with cancer. To be counted as cancer days, the Department will identify cancer days with any claim that contains a ICD-9-CM diagnosis code of 140.0 through 208.9 and 230.0 through 234.9 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004. To determine if 15 percent of the hospital Medicaid days were for treating cancer patients, the cancer days will be divided by the total Medicaid days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004.

2) "Crossover percentage adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Crossover percentage base period" means the information utilized in the Medicaid percentage adjustment determination as described in Section 148.122 for October 1, 2004.

4) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and is an urban hospital as described in Section 148.25(g)(4).

5) "Other urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a city with a population greater than 50,000 or a total population in excess of 100,000, and is an urban hospital as described in Section 148.25(g)(4).

6) "Total Medicaid days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, including days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's Medicaid percentage adjustment determination as described in Section 148.122 for October 1, 2004.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to

be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.418 Long Term Acute Care Hospital Adjustment Payments

a) Qualifying Criteria: Long Term Acute Care Hospital Adjustment Payments described in subsection (b) of this Section shall be made to an Illinois long term stay hospital, as defined in 89 Ill Adm. Code 149.50(c)(4), excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Long Term Acute Care Hospital Adjustment Payments

1) For a hospital qualifying under subsection (a) of this Section that qualified for a Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to the product of $125.00 multiplied by Medicaid inpatient days provided during the long term acute care hospital base period.

2) For a hospital qualifying under subsection (a) of this Section that did not qualify for Medicaid Percentage Adjustment Payments under Section 148.122 for the 12-month period beginning on October 1, 2004, the Department shall pay an amount equal to the product of $1,250.00 multiplied by Medicaid inpatient days of care provided during the long term acute care hospital base period.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements

annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the long term acute care hospital adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

1) "Long term acute care hospital adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

2) "Long term acute care hospital base period" means the 12-month period beginning on July 1, 2002 and ending on June 30, 2003.

3) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the long term care hospital base period that was adjudicated by the Department through June 30, 2004.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.420 Obstetrical Care Adjustment Payments

a) Qualifying Criteria. Obstetrical Care Adjustment Payments shall be made to a qualifying Illinois hospital that provided obstetrical care in the obstetrical base period. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment for the rate year 2006 determination.

b) The following classes of hospitals are ineligible for Obstetrical Care Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described inSection 148.25(b)(6).

c) Obstetrical Care Adjustment Payments

1) A hospital qualifying under subsection (a) of this Section shall receive payments equal to the product of $550.00 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.

2) For a hospital qualifying under subsection (a) of this Section that qualified for disproportionate share payment adjustments as described in Section

148.120 as of October 1, 2004,with a Medicaid obstetrical percentage greater than ten percent and a Medicaid emergency care percentage greater than 40 percent, shall receive payments equal to the product of $650.00 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.

3) For a hospital qualifying under subsection (a) of this Section located in the St. Louis Metropolitan statistical area, with more than 500 Medicaid obstetrical days, shall receive payments equal to the product of $1,800.00 multiplied by the qualifying hospital's Medicaid obstetrical days provided during the obstetrical care base period.

4) For a large urban hospital qualifying under subsection (a) of this Section that has a Medicaid obstetrical percentage greater than 25 percent and is in a county with an eligibility growth rate greater than 60 percent between the years 1998 and 2003, shall receive payments equal to the product of $600.00 multiplied by the qualifying hospital's Medicaid obstetrical days provided within the obstetrical care base period.

5) For a rural hospital as described in 148.25(g)(3) qualifying under subsection (a) designated as a Level II perinatal center as of January 1, 2005, with a MIUR greater than 34 percent in State fiscal year 2002 and a Medicaid obstetrical percentage greater than 15 percent, shall receive payment equal to the product of $400.00 multiplied by the hospital's Medicaid obstetrical days provided within the obstetrical care base period, multiplied by 6.

6) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the obstetrical care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of

September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

1) "Emergency care percentage" means a fraction, the numerator of which is the total Category 3 ambulatory procedure listing services provided by the hospital in State fiscal year 2003, and the denominator of which is the total ambulatory procedure listing services provided by the hospital in State fiscal year 2003.

2) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and is an urban hospital as described in Section 148.25(g)(4).

3) "Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, with a Diagnosis Related Grouping (DRG) of 370 through 375; excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the obstetrical base period the Department adjudicated through June 30, 2004.

4) "Medicaid obstetrical percentage" means the percentage used in the October 1, 2004, Medicaid percentage adjustment determination as described in Section 148.122.

5) "Obstetrical care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1

of the year and ending June 30 of the following year.

6) "Obstetrical care base period" means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.422 Outpatient Access Payments

a) Qualifying Criteria: Outpatient Access Payments, as described in subsection (b) of this Section, shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital shall qualify for payment if it was assessed as described in 89 Ill. Adm. Code 140.80 for the rate year 2006 determination, excluding the following hospitals:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Outpatient Access Payments

1) Outpatient access payments shall be made to a hospital qualifying under subsection (a) of this Section. Payment will equal 2.38 multiplied by the

hospital's outpatient ambulatory procedure listing payments for services provided in the outpatient access base period, multiplied by the change in the growth of Medicaid clients within the hospital's county from State fiscal year 1998 to State fiscal year 2003.

2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient access adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

1) "Outpatient access adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

2) "Outpatient access base period" means the 12-month period beginning on July 1, 2002, and ending June 30, 2003.

3) "Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover

days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient access base period that were adjudicated by the Department through June 30, 2004.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill Adm. Code 140.80 is in effect.

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

Section 148.424 Outpatient Utilization Payments

a) Qualifying Criteria: Outpatient Utilization Payments, as described in subsection (b) of this Section, shall be made to an Illinois hospital, excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Outpatient Utilization Adjustment Payments

1) A rural hospital, as described in Section 148.25(g)(3) and qualifying under subsection (a) of this Section, shall receive an amount equal to 1.7 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during the outpatient utilization adjustment base period.

2) An urban hospital, as described in Section 148.25(g)(4) and qualifying

under subsection (a) of this Section, shall receive an amount equal to 0.45 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during the outpatient utilization adjustment base period.

3) A hospital that enrolled to provide Medicaid services during State fiscal year 2003, shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient utilization adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) of this Section being met shall be paid within 100 days after the conditions described in subsection (e) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

1) "Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient access base period that were adjudicated by the Department through June 30, 2004.

2) "Outpatient utilization adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Outpatient utilization base period" means the 12-month period beginning on July 1, 2002, and ending June 30, 2003.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 IL Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 IL Adm. Code 140.80 is in effect.

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

Section148.426 Outpatient Complexity of Care Adjustment Payments

a) Qualifying Criteria: Outpatient Complexity of Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to Illinois hospitals located in an urban area excluding;

1) County-owned hospitals, as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Outpatient Complexity of Care Adjustment Payments

1) Each hospital qualifying under subsection (a) of this Section will receive a payment equal to the product of 2.55, multiplied by the hospital's emergency care percentage, multiplied by the hospital's ambulatory procedure listing payments.

2) Each children's hospital qualifying under subsection (a) of this Section,

with a Medicaid inpatient utilization rate greater than 90 percent used for the October 1, 2004, Medicaid percentage adjustment determination described in Section 148.122 shall have the adjustment, as calculated in subsection (b)(1), multiplied by 2.

3) Each cancer center hospital qualifying under subsection (a) of this Section, shall have the adjustment, as calculated in (b)(1), multiplied by 3.

4) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient complexity of care adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

1) "Cancer center hospital" means an Illinois hospital that has received the approval of the American College of Surgeons Commission on Cancer as of June 16, 2005 and provides more than 15 percent of the hospital Medicaid days in State fiscal year 2003 for treating patients with cancer. To be counted as cancer days, the Department will identify cancer days with any claim that contains a ICD-9-CM diagnosis code of 140.0 through 208.9 and 230.0 through 234.9 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the

State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004. To determine if 15 percent of the hospital Medicaid days were for treating cancer patients, the cancer days will be divided by the total Medicaid days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, as tabulated from the Department's paid claims data for admissions occurring in the State fiscal year 2003 base period that were adjudicated by the Department through June 30, 2004.

2) "Emergency care percentage" means a fraction, the numerator of which is the total Group 3 ambulatory procedure listing services as described in Section 148.140(b)(1)(C) provided by the hospital in State fiscal year 2003, and the denominator of which is the total ambulatory procedure listing services as described in Section 148.140(b)(1) provided by the hospital in State fiscal year 2003.

3) "Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient access base period that were adjudicated by the Department through June 30, 2004.

4) "Outpatient complexity of care adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

5) "Outpatient complexity of care base period" means the 12-month period beginning on July 1, 2002, and ending June 30, 2003.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State plan amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.428 Rehabilitation Hospital Adjustment Payments

a) Qualifying Criteria. Rehabilitation Hospital Adjustment Payments, as described in subsection (c) of this Section, shall be made to a qualifying Illinois freestanding rehabilitation hospitals that did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning on October 1, 2004, if not otherwise excluded under subsection (b) of this Section.

b) The following classes of hospitals are ineligible for Rehabilitation Hospital Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described in 89 Ill. Adm. Code 148.25(b)(6).

c) Rehabilitation Hospital Adjustment Payments for hospitals qualifying under subsection (a) of this Section will receive an amount equal to three multiplied by the hospital's outpatient ambulatory procedure listing payments for Group 6A services provided during the rehabilitation hospital base period.

d) Payment to a Qualifying Hospital

1) For the rehabilitation hospital adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid

to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days hospital was open during the fiscal year.

e) Definitions

1) "Outpatient ambulatory procedure listing payments for Group 6A services" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1)(F), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the rehabilitation hospital base period that were adjudicated by the Department through June 30, 2004.

2) "Rehabilitation hospital adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Rehabilitation hospital base period" means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.430 Perinatal Outpatient Adjustment Payments

a) Qualifying Criteria. Perinatal Outpatient Adjustment Payments shall be made to qualifying general acute care hospitals that are designated as a perinatal center as of January 1, 2005. A hospital not otherwise excluded under subsection (b) of this Section for the perinatal outpatient adjustment period determination shall qualify for payment if the hospital:

1) Is located in a large urban area;

2) Has a Medicaid obstetrical percentage of at least ten percent used for the October 1, 2004, Medicaid percentage adjustment determination as described in Section 148.122;

3) Has a Medicaid intensive care unit percentage of at least three percent; and

4) Has a ratio of ambulatory procedure listing for total Group 3 services, described in Section 148.140(b)(1)(C), to total ambulatory procedure services, as described in Section 148.140(b)(1), of at least 50 percent.

b) The following classes of hospitals are ineligible for Perinatal Outpatient Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(6).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

c) Perinatal Outpatient Adjustment Payments

1) A hospital qualifying under subsection (a) of this Section shall receive payment equal to the product of $550.00 multiplied by the hospital's ambulatory procedure listing for emergency level I services described in Section 148.140(b)(1)(C)(i) provided in the perinatal outpatient base period.

2) For a hospital that as of January 1, 2005 was designated a Level II+ or III perinatal center qualifying under subsection (a) of this Section, the payment calculated in subsection (c)(1) will be multiplied by four.

3) A hospital that enrolled to provide Medicaid services during state fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being preformed under this subsection (c).

d) Payment to a Qualifying Hospital

1) For the perinatal outpatient adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March, and May. The sum of the amounts required prior to the conditions described in subsection (f) of this Section being met shall be paid within 100 days after the conditions described in subsection (f) have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

e) Definitions

1) "Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget, 725 17th Street N.W., Washington D.C. 20503, in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000, and is an urban hospital as described in Section 148.25(g)(4).

2) "Medicaid intensive care unit percentage" means a fraction, the numerator

of which is the number of hospital inpatient days during which Medicaid recipients received intensive care services from the hospital, as determined from the hospital's fiscal year 2002 Medicaid cost report on file with the Department as of July 1, 2004, and the denominator of which is the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as contained on the hospital's cost report on file with the Department as of July 1, 2004, for the hospital's fiscal year ending in 2002.

3) "Outpatient ambulatory procedure listing emergency level I services" means, for a given hospital, the sum of services for ambulatory procedure listing services as described in Section 148.140(b)(1)(C)(i), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the perinatal outpatient base period that were adjudicated by the Department through June 30, 2004.

4) "Perinatal outpatient adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

5) "Perinatal outpatient base period" means the 12-month period beginning on July 1, 2002, and ending on June 30, 2003.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.432 Supplemental Psychiatric Adjustment Payments

a) Qualifying criteria: Supplemental Psychiatric Adjustment Payments shall be made to a qualifying hospital as defined in this subsection (a). An Illinois hospital shall qualify for payment if it did not qualify for Medicaid Percentage Adjustment Payments as described in Section 148.122 for the 12-month period beginning October 1, 2004, but is eligible for psychiatric adjustment payments as described in Section 148.105 for fiscal year 2005, excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Supplemental Psychiatric Adjustment Payments will be made to qualifying hospitals and will equal the product of the hospitals fiscal year 2005 Psychiatric Adjustment Payments, as described in Section 148.105, multiplied by 0.7.

c) Payment to a Qualifying Hospital

1) For the supplemental psychiatric adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (e) being met shall be paid within 100 days after the conditions described in subsection (e) of this Section have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) "Supplemental base rate adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006 means the 12-month period beginning July 1 of the year and ending June 30 of the following year.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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

Section 148.434 Outpatient Community Access Adjustment Payments

a) Qualifying criteria: Outpatient Community Access Adjustment Payments, as described in subsection (b) of this Section, shall be made to an Illinois general acute care hospital as described in Section 148.270(c)(1) that is designated as a perinatal center as of January 1, 2005, that had a Medicaid obstetrical percentage used for the October 1, 2004 Medicaid percentage adjustment determination described in Section 148.122 of at least 12.5 percent, that had a ratio of crossover days to total Medicaid days, greater than or equal to 25 percent utilizing information used for the Medicaid Percentage Adjustment Payment described in Section, and that qualified for Medicaid Percentage Adjustment Payments as described in Section 148.122 on October 1, 2004, excluding:

1) County-owned hospitals as described in Section.148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Outpatient Community Access Adjustment Payments

1) Hospitals qualifying under subsection (a) of this Section shall receive an amount equal to $100.00 multiplied by the hospital's outpatient ambulatory procedure listing services in the outpatient community access base period.

2) A hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being preformed under this subsection (b).

c) Payment to a Qualifying Hospital

1) For the outpatient community access adjustment period for fiscal year 2006, fiscal year 2007 and fiscal year 2008 total payments will equal the methodologies described in this subsection (c) and shall be paid to the hospital in four equal installments on or before the seventh State business day of September, December, March and May. The sum of the amounts required prior to the conditions described in subsection (f) being met shall be paid within 100 days after the conditions described in subsection (f) of this Section have been met.

2) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.

d) Definitions

1) "Outpatient ambulatory procedure listing services" means, for a given hospital, the sum of services for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient community access base period that were adjudicated by the Department through June 30, 2004.

2) "Outpatient community access adjustment period" means, beginning August 1, 2005, the 11-month period beginning on August 1, 2005 and ending June 30, 2006, and beginning July 1, 2006, the 12 month period beginning July 1 of the year and ending June 30 of the following year.

3) "Outpatient community access base period" means the 12-month period beginning on July 1, 2002, and ending June 30, 2003.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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