

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.463 Clinic Service Payment

a) Definitions

“Behavioral Health Services”, for the purposes of this Section, means services provided by a licensed clinical psychologist or licensed clinical social worker.

“Center”, for the purposes of this Section, means both a federally qualified health center and a rural health clinic.

“Federally Qualified Health Center” (FQHC) means a health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Services Administration, U.S. Department of Health and Human Services.

“Rural Health Clinic” (RHC) means a health care provider that has been designated by the Public Health Service, U.S. Department of Health and Human Services, or by the Governor, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) to be an RHC.

b) Reimbursement

The Center will be reimbursed under a prospective payment system for 100 percent of the average of the costs that are reasonable and related to the cost of furnishing such services by the Center in accordance with the provisions of federal law (42 USC 1396a(aa)). Baseline payment rates will be determined individually for each enrolled Center. Once determined, the baseline payment rate will be adjusted annually using the Medicare Economic Index (MEI). Payment for services provided on or after January 1, 2001, shall be made using specific rates for each Center as specified in this Section.

1) Baseline Payment Rates

A) For each Center, the Department will calculate a baseline medical encounter rate and, for each Center that is enrolled with the Department to provide Behavioral Health Services or dental services, the Department will calculate a baseline Behavioral Health Services or dental encounter rate, using the methodology specified in this subsection (b).

i) The cost basis for the baseline rates shall be drawn

from individual Center cost reports for Center fiscal years ending in 1999 and 2000 or, in the instance of a Center that did not operate during the entirety of those periods, cost reports that cover the portions of those periods during which the Center was in operation.

ii) Pending federal approval, for dates of service provided by an FQHC on or after January 1, 2006, the cost basis for the baseline rates shall be the greater of an encounter rate using the criteria under (b)(1)(A)(i) above, or the same criteria that uses the Center's cost reports ending in 2002 and 2003 in place of cost reports ending in 1999 and 2000.

B) The baseline payment rates shall be based upon allowable costs, reported by the Center, that are determined by the Department to be reasonable and efficient. The method for determining allowable cost factors is similar to that used for Medicare (42 USC 1395g), with the following significant differences. The Department's methodology shall:

i) Consider costs associated with services not covered under Medicare (e.g., pharmacy, patient transportation, medical case management, health education, nutritional counseling).

ii) Apply reasonable constraints on allowable cost, as described in subsection (b)(10) of this Section.

iii) Apply reasonable constraints on the total cost per encounter.

C) The baseline payment rates for a Center shall be the average (arithmetic mean) of the annual reasonable costs per encounter, calculated separately for each of the fiscal years for which cost report data must be submitted using the methodology specified in subsections (b)(2), (3) and (4) of this Section for the medical encounter rate, dental encounter rate, and Behavioral Health Services encounter rate, respectively.

2) Annual Reasonable Cost Per Medical Encounter

A) The annual reasonable cost per medical encounter shall be

the lesser of:

- i) The annual cost per encounter, as calculated in subsection (b)(2)(D) of this Section; or
- ii) The reasonable cost of providing a medical encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

B) The core services component.

The core services component is the sum of the following two components:

- i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost, as defined in subsection (b)(1)(B) of this Section, for core services divided by the greater of the number of encounters reported by direct staff (e.g., staff specified in subsection (b)(10)(A) and, for the determination of encounter payment rates effective prior to January 1, 2002, subsection (b)(10)(C)); or the number of encounters resulting from the application of the minimum efficiency standards found in subsections (b)(10)(A) and (b)(10)(C); and
- ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

C) Supplemental services component.

The supplemental services component is the sum of the following two components:

- i) The allowable supplemental cost per encounter, which is the quotient of the cost of services (e.g., pharmacy, patient transportation, medical case management, health education, nutritional counseling), excepting core services, dental services and, effective January 1, 2002, Behavioral Health Services, provided by the Center, divided by the greater of the number of encounters reported by direct staff; or the number of encounters resulting from application of the minimum productivity standards found in subsections (b)(10)(A) and

(b)(10)(C) of this Section; and

- ii) The allowable overhead cost per encounter, which is the product of the allowable supplemental cost per encounter multiplied by the Center's allowable overhead rate factor.

- D) Annual cost per encounter.
The annual cost per medical encounter is the sum of the core services component, as determined in subsection (b)(2)(B) of this Section, and the supplemental services component, as determined in subsection (b)(2)(C).

3) Annual Reasonable Cost Per Dental Encounter

- A) The annual reasonable cost per dental encounter shall be the lesser of:
 - i) The annual cost per encounter, as calculated in subsection (b)(3)(B) of this Section; or
 - ii) The reasonable cost of providing a dental encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

- B) Annual cost per encounter.
The annual cost per encounter is the sum of the following two components:

- i) The allowable direct cost per encounter, which is the quotient of the allowable direct dental cost, as defined in subsection (b)(1)(B), divided by the greater of the number of encounters reported by direct dental staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b) (10)(B); and
- ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

4) Annual Reasonable Cost Per Behavioral Health Service Encounter
Effective for services provided on or after January 1, 2002, a separate annual reasonable cost per Behavioral Health Service

encounter shall be determined.

- A) The annual reasonable cost per Behavioral Health Service encounter shall be the lesser of the following:
 - i) The annual cost per encounter, as calculated in subsection (b)(4)(B) of this Section.
 - ii) The reasonable cost of providing a Behavioral Health Service encounter, which shall be 105 percent of the Statewide median of the calculated annual cost per encounter for FQHCs or RHCs, as the case may be.
- B) Annual cost per encounter.
The annual cost per encounter is the sum of the following two components:
 - i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost for Behavioral Health Services, as defined in subsection (b)(1)(B) of this Section, divided by the greater of the number of encounters reported by direct behavioral health staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b)(10)(C); and
 - ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.
- 5) For any individual eligible under the medical assistance programs, a Center may bill only one medical encounter, one dental encounter, and one behavioral health encounter per day. A Center will be reimbursed for a service only if it has enrolled with the Department to provide that service.
- 6) Claims submitted to the Department must identify all services provided during the encounter.
- 7) Cost Basis
Each Center must annually complete a cost report, in a format specified by the Department, for the Center's fiscal year. Each FQHC must also annually submit a copy of financial statements audited by an independent Certified Public Accountant. The cost

report and audited financial statements must be filed with the Department within 180 days after the close of the Center's fiscal year, except for cost reports and audited financial statements for Center fiscal years 1999 and 2000 which, in the case of FQHCs, must be filed with the Department no later than November 30, 2001, and in the case of RHCs, must be filed no later than March 30, 2002. Except for the first year during which the Center begins operations, the cost report must cover a full fiscal year ending on June 30 or other fiscal year that has been approved by the Department. Payments will be withheld from any Center that has not submitted the cost report by the applicable filing date, and no payments will be made until such time as the reports or audited statements are received and approved by the Department.

- 8) Establishment of Initial Year Payment Amount for a New Center
For any Center that begins operation on or after January 1, 2001, the payment rate per encounter shall be the median of the payment rates per encounter of neighboring FQHCs or RHCs with similar caseloads, as determined by the Department. If the Department determines that there are no such comparable Centers, then the rate per encounter shall be the median of the payment rates per encounter Statewide for all FQHCs or RHCs, as the case may be.
- 9) Rate Adjustments
 - A) Initial rate determinations.
 - i) On or about January 1, 2002, the Department shall determine the medical and dental encounter rates for each participating FQHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected FQHC.
 - ii) On or about January 1, 2003, the Department shall determine the medical and dental encounter rates for each participating RHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected RHC.
 - B) Annual adjustment.

- i) Beginning January 1, 2002, and annually thereafter, except as specified in subsection (b)(9)(B)(ii) of this Section, the Department will adjust baseline rates by the most recently available MEI. The adjusted rates shall be paid for services provided on or after the date of adjustment.
- ii) In the instance of a Center that provided Behavioral Health Services prior to January 1, 2002, for the purpose of applying the January 1, 2002, adjustment by the most recently available MEI, the baseline medical services encounter rate applicable for services provided from January 1, 2001, through December 31, 2001, shall be redetermined after removal of costs and encounters attributable to Behavioral Health Services.

C) Scope of service adjustment.

If a Center significantly changes its scope of services, the Center may request that new baseline encounter rates be determined. Adjustments to encounter rates will be made only if the change in the scope of services results in the inclusion of Behavioral Health Services or dental services or a difference of at least five percent from the Center's current rate. The Department may initiate a rate adjustment, based on audited financial statements or cost reports, if the scope of services has been modified to include Behavioral Health Services or dental services or would otherwise result in a change of at least five percent from the Center's current rate.

10) Reasonable Cost Considerations

The following minimum efficiency standards will be applied to determine reasonable cost:

A) Medical direct care productivity.

The Center must average 4,200 encounters annually per full-time equivalent (FTE) for physicians and 2,100 encounters per FTE for mid-level health care staff (i.e., physician assistants, nurse practitioners, specialized nurse practitioners and nurse midwives).

B) Dental direct care productivity.

The Center must average 1.5 encounters per hour per FTE for dentists.

- C) Behavioral health direct care productivity.
The Center must average 2,100 annual encounters per FTE for licensed clinical psychologists and licensed clinical social workers.
 - D) Guideline for non-physician health care staff.
The maximum ratio of staff is four FTE non-physician health care staff for each FTE staff subject to the direct care productivity standards in subsections (b)(10)(A) and (B) of this Section.
 - E) Allowable overhead.
The maximum Medicaid allowable overhead cost is 35 percent of allowable total cost.
- 11) Adjustments for Medical Services Paid for by a Managed Care Organization (MCO)
The Department shall make payment adjustments to a Center if it provides care through a contractual arrangement with a Medicaid MCO and is reimbursed an amount, reported to the Department, that is less than the minimum payment required in 42 USC 1396a(aa). The amount of any such payment adjustment shall be at a fixed annual rate as determined by the Department. For each Center so eligible, a payment adjustment shall take into consideration the total payments made by the MCO to the Center (including all payments made on a service-by-service, encounter or capitation basis). In the event that Center cost data related to MCO services are unavailable to the Department, an estimate of such costs may be used that takes into consideration other relevant data. Adjustments will be made, at least quarterly, only for Medicaid eligible services. All such services must be defined in a contract between the Center and the MCO. Such contracts must be made available to the Department.
- 12) Audits
All cost reports will be audited by the Department. The Center will be advised of any adjustment resulting from these audits.
- 13) Alternate Payment Methodology for Government-Operated Centers
- A) A Center operated by a State or local government agency may elect to be reimbursed under the alternate payment methodology described in this subsection (b)(13).

- B) The State or local government agency shall enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to services provided by the Center and the funding of those services.
 - C) The Center operated by a State or local government agency shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section.
 - D) The State or local government agency shall certify the expenditure of public funds in excess of reimbursement received from the Department, under subsection (b)(13)(C) of this Section, and any reimbursement from other payers (e.g., an insurance company, a managed care organization) for services provided to individuals eligible for medical assistance programs administered by the Department, provided the funds were not derived from a federal funding source or were not otherwise used as a State or local match for federal funds. The certification shall be in the form and format specified by the Department. The certification shall be filed within 30 days after the submission of the annual cost report. The certification shall compare expenditures within that cost reporting period to payments received or receivable for that same period.
 - E) The certified expenditures shall be used by the Department to claim federal financial participation. Federal funds resulting from the claiming of the certified expenditures shall be distributed, according to the provisions of the agreement referenced in subsection (b)(13)(B) of this Section, to the State or the government agency that operates the Center that provided the services.
- 14) Alternate Payment Methodology for Certain Qualifying Centers
- A) No later than 30 days after the initial rate determination specified in subsection (b)(9)(A) of this Section, the Department shall determine the eligibility of each Center for this alternative payment methodology. A Center will qualify for this alternative payment methodology if the Department's estimate of the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the reimbursement policy and rates in effect prior to the initial rate

determination, is greater than the total amount that will be paid for those same services under the initial rates. The Department shall notify each qualifying Center, in writing, of the result of this determination.

- B) A qualifying Center may, for services provided from January 1, 2002, through December 31, 2002, elect to be reimbursed under the alternate payment methodology described in this subsection (b)(14). A qualifying Center must notify the Department, in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternative payment methodology.
 - C) A Center electing this alternative payment system shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section, except the medical encounter payment rate shall be increased by an amount equal to twice the quotient resulting from the Department's estimate of the difference between the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the initial rates as determined in subsection (b)(9)(A); and the total amount that would have been paid under the payment rates in effect prior to the initial rate determination, divided by the Department's estimate of total medical encounters during the 12-month period ending December 31, 2001.
- 15) **Alternate Behavioral Health Payment Methodology for Certain Qualifying Centers**
Centers that are certified by the Department of Human Services, Office of Mental Health, or the Department of Children and Family Services to provide Behavioral Health Services may elect an alternate payment methodology for their Behavioral Health Services. An election of this alternate payment methodology will allow the Centers to be reimbursed under the provisions of 59 Ill. Adm. Code 132 for Behavioral Health Services provided. A qualifying Center must notify the Department in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternate payment methodology.
- 16) All service sites operated by a Center shall be reimbursed using the Center's established encounter rates, except in the instance where the site submitted separate cost reports ~~for fiscal years ending in~~

~~1999 and 2000~~ and separate baseline rates were determined for the site.

c) Rate Appeals Process

- 1) All appeals of audit adjustments or rate determinations must be submitted in writing to the Department. Appeals must be submitted within 60 calendar days after the notification of such adjustments or rate determinations. If upheld, the revised audit adjustment or rate determination shall be made effective as of the beginning of the rate period.
- 2) To be accepted for review, the written appeal shall include the following:
 - A) The current approved reimbursement rate, allowable costs, and the additional reimbursable costs sought through the appeal.
 - B) A clear, concise statement of the basis for the appeal.
 - C) A detailed statement of financial, statistical, and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement.
 - D) A statement by the Center's chief executive officer or financial officer that the application of the rate appeal and information contained in the Center's reports, schedules, budgets, books, and records submitted are true and accurate.
- 3) Rate appeals may be considered for the following reasons:
 - A) Mechanical or clerical errors committed by the provider in reporting historical expenses used in the calculation of allowable costs.
 - B) Mechanical or clerical errors committed by the Department in auditing historical expenses as reported and/or in calculating reimbursement rates.
- 4) The Department shall rule on all appeals within 120 calendar days after receipt of the complete appeal, except that, if additional information is required from the facility, the period shall be

extended until such time as the information is provided.

- 5) Appeals shall be submitted to the Department's Office of Health Finance, 201 South Grand Avenue East ~~1001 North Walnut Street~~, Springfield, Illinois 62763-0002 ~~0001~~.

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