

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
140.11	Amendment
140.16	Amendment
140.71	Amendment
140.402	Amendment
140.459	Amendment
140.461	Amendment
140.462	Amendment
140.464	Amendment
140.930	Amendment
140.Table J	New
140.Table M	Repeal
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11].
- 5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? Yes
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other rulemakings pending on this Part? Yes

<u>Sections</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
140.462	Amendment	37 Ill. Reg. 12637; August 16, 2013
140.12	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.440	Amendment	37 Ill. Reg. 19971; December 20, 2013

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140.2	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.3	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.6	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.441	Amendment	38 Ill. Reg. 2529; January 17, 2014

11) Statement of Statewide Policy Objectives: These proposed amendments neither create nor expand any State mandate affecting units of local government.

12) Information and questions regarding this amendment shall be directed to:

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

217/782-1233

HFS.Rules@illinois.gov.

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this Rulemaking was Summarized: January 2014

The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 140

MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

Section

- 140.1 Incorporation By Reference
- 140.2 Medical Assistance Programs

EMERGENCY

- 140.3 Covered Services Under Medical Assistance Programs

EMERGENCY

- 140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
- 140.5 Covered Medical Services Under General Assistance
- 140.6 Medical Services Not Covered

EMERGENCY

- 140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
- 140.8 Medical Assistance For Qualified Severely Impaired Individuals
- 140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
- 140.10 Medical Assistance Provided to Persons Confined or Detained by the Criminal Justice System

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section

- 140.11 Enrollment Conditions for Medical Providers
- 140.12 Participation Requirements for Medical Providers
- 140.13 Definitions
- 140.14 Denial of Application to Participate in the Medical Assistance Program
- 140.15 Suspension and Denial of Payment, Recovery of Money and Penalties
- 140.16 Termination, Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance

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- Program
- 140.18 Effect of Termination, Suspension, Exclusion or Revocation on Persons Associated with Vendor
 - 140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension, Exclusion or Barring
 - 140.20 Submittal of Claims
 - 140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
 - 140.22 Magnetic Tape Billings (Repealed)
 - 140.23 Payment of Claims
 - 140.24 Payment Procedures
 - 140.25 Overpayment or Underpayment of Claims
 - 140.26 Payment to Factors Prohibited
 - 140.27 Assignment of Vendor Payments
 - 140.28 Record Requirements for Medical Providers
 - 140.30 Audits
 - 140.31 Emergency Services Audits
 - 140.32 Prohibition on Participation, and Special Permission for Participation
 - 140.33 Publication of List of Sanctioned Entities
 - 140.35 False Reporting and Other Fraudulent Activities
 - 140.40 Prior Approval for Medical Services or Items
 - 140.41 Prior Approval in Cases of Emergency
 - 140.42 Limitation on Prior Approval
 - 140.43 Post Approval for Items or Services When Prior Approval Cannot Be Obtained
 - 140.44 Withholding of Payments Due to Fraud or Misrepresentation
 - 140.45 Withholding of Payments Upon Provider Audit, Quality of Care Review, Credible Allegation of Fraud or Failure to Cooperate
 - 140.55 Recipient Eligibility Verification (REV) System
 - 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments
 - 140.72 Drug Manual (Recodified)
 - 140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS

- Section
- 140.80 Hospital Provider Fund
 - 140.82 Developmentally Disabled Care Provider Fund
 - 140.84 Long Term Care Provider Fund

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- 140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust
Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
- 140.95 Hospital Services Trust Fund
- 140.96 General Requirements (Recodified)
- 140.97 Special Requirements (Recodified)
- 140.98 Covered Hospital Services (Recodified)
- 140.99 Hospital Services Not Covered (Recodified)
- 140.100 Limitation On Hospital Services (Recodified)
- 140.101 Transplants (Recodified)
- 140.102 Heart Transplants (Recodified)
- 140.103 Liver Transplants (Recodified)
- 140.104 Bone Marrow Transplants (Recodified)
- 140.110 Disproportionate Share Hospital Adjustments (Recodified)
- 140.116 Payment for Inpatient Services for GA (Recodified)
- 140.117 Hospital Outpatient and Clinic Services (Recodified)
- 140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
- 140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
- 140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
- 140.203 Limits on Length of Stay by Diagnosis (Recodified)
- 140.300 Payment for Pre-operative Days and Services Which Can Be Performed in an
Outpatient Setting (Recodified)
- 140.350 Copayments (Recodified)
- 140.360 Payment Methodology (Recodified)
- 140.361 Non-Participating Hospitals (Recodified)
- 140.362 Pre July 1, 1989 Services (Recodified)
- 140.363 Post June 30, 1989 Services (Recodified)
- 140.364 Prepayment Review (Recodified)
- 140.365 Base Year Costs (Recodified)
- 140.366 Restructuring Adjustment (Recodified)
- 140.367 Inflation Adjustment (Recodified)
- 140.368 Volume Adjustment (Repealed)
- 140.369 Groupings (Recodified)
- 140.370 Rate Calculation (Recodified)
- 140.371 Payment (Recodified)
- 140.372 Review Procedure (Recodified)
- 140.373 Utilization (Repealed)
- 140.374 Alternatives (Recodified)
- 140.375 Exemptions (Recodified)
- 140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)
- 140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)

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NOTICE OF PROPOSED AMENDMENTS

- 140.391 Definitions (Recodified)
- 140.392 Types of Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.398 Hearings (Recodified)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

- Section
- 140.400 Payment to Practitioners
- 140.402 Copayments for Noninstitutional Medical Services
- 140.403 Telehealth Services
- 140.405 Non-Institutional Rate Reductions
- 140.410 Physicians' Services
- 140.411 Covered Services By Physicians
- 140.412 Services Not Covered By Physicians
- 140.413 Limitation on Physician Services
- 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers
- 140.416 Optometric Services and Materials
- 140.417 Limitations on Optometric Services
- 140.418 Department of Corrections Laboratory
- 140.420 Dental Services
- 140.421 Limitations on Dental Services
- 140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items – Dentists (Repealed)
- 140.425 Podiatry Services
- 140.426 Limitations on Podiatry Services
- 140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items – Podiatry (Repealed)
- 140.428 Chiropractic Services
- 140.429 Limitations on Chiropractic Services (Repealed)
- 140.430 Independent Clinical Laboratory Services
- 140.431 Services Not Covered by Independent Clinical Laboratories
- 140.432 Limitations on Independent Clinical Laboratory Services
- 140.433 Payment for Clinical Laboratory Services
- 140.434 Record Requirements for Independent Clinical Laboratories
- 140.435 Advanced Practice Nurse Services
- 140.436 Limitations on Advanced Practice Nurse Services
- 140.438 Diagnostic Imaging Services

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- 140.440 Pharmacy Services
- 140.441 Pharmacy Services Not Covered
- EMERGENCY
- 140.442 Prior Approval of Prescriptions
- 140.443 Filling of Prescriptions
- 140.444 Compounded Prescriptions
- 140.445 Legend Prescription Items (Not Compounded)
- 140.446 Over-the-Counter Items
- 140.447 Reimbursement
- 140.448 Returned Pharmacy Items
- 140.449 Payment of Pharmacy Items
- 140.450 Record Requirements for Pharmacies
- 140.451 Prospective Drug Review and Patient Counseling
- 140.452 Mental Health Services
- 140.453 Definitions
- 140.454 Types of Mental Health Services
- 140.455 Payment for Mental Health Services
- 140.456 Hearings
- 140.457 Therapy Services
- 140.458 Prior Approval for Therapy Services
- 140.459 Payment for Therapy Services
- 140.460 Clinic Services
- 140.461 Clinic Participation, Data and Certification Requirements
- 140.462 Covered Services in Clinics
- 140.463 Clinic Service Payment
- 140.464 Hospital-Based and Encounter Rate Clinic Payments
- 140.465 Speech and Hearing Clinics (Repealed)
- 140.466 Rural Health Clinics (Repealed)
- 140.467 Independent Clinics
- 140.469 Hospice
- 140.470 Eligible Home Health Care, Nursing and Public Health Providers
- 140.471 Description of Home Health Care Services
- 140.472 Types of Home Health Care Services
- 140.473 Prior Approval for Home Health Care Services
- 140.474 Payment for Home Health Care Services
- 140.475 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
- 140.476 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices for Which Payment Will Not Be Made
- 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices
- 140.478 Prior Approval for Medical Equipment, Supplies, Prosthetic Devices and Orthotic

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NOTICE OF PROPOSED AMENDMENTS

Devices

- 140.479 Limitations, Medical Supplies
- 140.480 Equipment Rental Limitations
- 140.481 Payment for Medical Equipment, Supplies, Prosthetic Devices and Hearing Aids
- 140.482 Family Planning Services
- 140.483 Limitations on Family Planning Services
- 140.484 Payment for Family Planning Services
- 140.485 Healthy Kids Program
- 140.486 Illinois Healthy Women
- 140.487 Healthy Kids Program Timeliness Standards
- 140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures
- 140.490 Medical Transportation
- 140.491 Limitations on Medical Transportation
- 140.492 Payment for Medical Transportation
- 140.493 Payment for Helicopter Transportation
- 140.494 Record Requirements for Medical Transportation Services
- 140.495 Psychological Services
- 140.496 Payment for Psychological Services
- 140.497 Hearing Aids
- 140.498 Fingerprint-Based Criminal Background Checks

SUBPART E: GROUP CARE

Section

- 140.500 Long Term Care Services
- 140.502 Cessation of Payment at Federal Direction
- 140.503 Cessation of Payment for Improper Level of Care
- 140.504 Cessation of Payment Because of Termination of Facility
- 140.505 Informal Hearing Process for Denial of Payment for New ICF/MR
- 140.506 Provider Voluntary Withdrawal
- 140.507 Continuation of Provider Agreement
- 140.510 Determination of Need for Group Care
- 140.511 Long Term Care Services Covered By Department Payment
- 140.512 Utilization Control
- 140.513 Notification of Change in Resident Status
- 140.514 Certifications and Recertifications of Care (Repealed)
- 140.515 Management of Recipient Funds – Personal Allowance Funds
- 140.516 Recipient Management of Funds
- 140.517 Correspondent Management of Funds
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- 140.519 Use or Accumulation of Funds
- 140.520 Management of Recipient Funds – Local Office Responsibility
- 140.521 Room and Board Accounts
- 140.522 Reconciliation of Recipient Funds
- 140.523 Bed Reserves
- 140.524 Cessation of Payment Due to Loss of License
- 140.525 Quality Incentive Program (QUIP) Payment Levels
- 140.526 County Contribution to Medicaid Reimbursement (Repealed)
- 140.527 Quality Incentive Survey (Repealed)
- 140.528 Payment of Quality Incentive (Repealed)
- 140.529 Reviews (Repealed)
- 140.530 Basis of Payment for Long Term Care Services
- 140.531 General Service Costs
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- 140.533 General Administration Costs
- 140.534 Ownership Costs
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- 140.536 Organization and Pre-Operating Costs
- 140.537 Payments to Related Organizations
- 140.538 Special Costs
- 140.539 Reimbursement for Basic Nursing Assistant, Developmental Disabilities Aide, Basic Child Care Aide and Habilitation Aide Training and Nursing Assistant Competency Evaluation
- 140.540 Costs Associated With Nursing Home Care Reform Act and Implementing Regulations
- 140.541 Salaries Paid to Owners or Related Parties
- 140.542 Cost Reports – Filing Requirements
- 140.543 Time Standards for Filing Cost Reports
- 140.544 Access to Cost Reports (Repealed)
- 140.545 Penalty for Failure to File Cost Reports
- 140.550 Update of Operating Costs
- 140.551 General Service Costs Updates
- 140.552 Nursing and Program Costs
- 140.553 General Administrative Costs Updates
- 140.554 Component Inflation Index (Repealed)
- 140.555 Minimum Wage
- 140.560 Components of the Base Rate Determination
- 140.561 Support Costs Components
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- 140.565 Koshers Kitchen Reimbursement
- 140.566 Out-of-State Placement
- 140.567 Level II Incentive Payments (Repealed)
- 140.568 Duration of Incentive Payments (Repealed)
- 140.569 Clients With Exceptional Care Needs
- 140.570 Capital Rate Component Determination
- 140.571 Capital Rate Calculation
- 140.572 Total Capital Rate
- 140.573 Other Capital Provisions
- 140.574 Capital Rates for Rented Facilities
- 140.575 Newly Constructed Facilities (Repealed)
- 140.576 Renovations (Repealed)
- 140.577 Capital Costs for Rented Facilities (Renumbered)
- 140.578 Property Taxes
- 140.579 Specialized Living Centers
- 140.580 Mandated Capital Improvements (Repealed)
- 140.581 Qualifying as Mandated Capital Improvement (Repealed)
- 140.582 Cost Adjustments
- 140.583 Campus Facilities
- 140.584 Illinois Municipal Retirement Fund (IMRF)
- 140.590 Audit and Record Requirements
- 140.642 Screening Assessment for Nursing Facility and Alternative Residential Settings and Services
- 140.643 In-Home Care Program
- 140.645 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21 (Repealed)
- 140.646 Reimbursement for Developmental Training (DT) Services for Individuals With Developmental Disabilities Who Reside in Long Term Care (ICF and SNF) and Residential (ICF/MR) Facilities
- 140.647 Description of Developmental Training (DT) Services
- 140.648 Determination of the Amount of Reimbursement for Developmental Training (DT) Programs
- 140.649 Effective Dates of Reimbursement for Developmental Training (DT) Programs
- 140.650 Certification of Developmental Training (DT) Programs
- 140.651 Decertification of Day Programs
- 140.652 Terms of Assurances and Contracts
- 140.680 Effective Date Of Payment Rate
- 140.700 Discharge of Long Term Care Residents
- 140.830 Appeals of Rate Determinations
- 140.835 Determination of Cap on Payments for Long Term Care (Repealed)

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SUBPART F: FEDERAL CLAIMING FOR STATE AND
LOCAL GOVERNMENTAL ENTITIES

Section	
140.850	Reimbursement of Administrative Expenditures
140.855	Administrative Claim Review and Reconsideration Procedure
140.860	County Owned or Operated Nursing Facilities
140.865	Sponsor Qualifications (Repealed)
140.870	Sponsor Responsibilities (Repealed)
140.875	Department Responsibilities (Repealed)
140.880	Provider Qualifications (Repealed)
140.885	Provider Responsibilities (Repealed)
140.890	Payment Methodology (Repealed)
140.895	Contract Monitoring (Repealed)
140.896	Reimbursement For Program Costs (Active Treatment) For Clients in Long Term Care Facilities For the Developmentally Disabled (Recodified)
140.900	Reimbursement For Nursing Costs For Geriatric Residents in Group Care Facilities (Recodified)
140.901	Functional Areas of Needs (Recodified)
140.902	Service Needs (Recodified)
140.903	Definitions (Recodified)
140.904	Times and Staff Levels (Repealed)
140.905	Statewide Rates (Repealed)
140.906	Reconsiderations (Recodified)
140.907	Midnight Census Report (Recodified)
140.908	Times and Staff Levels (Recodified)
140.909	Statewide Rates (Recodified)
140.910	Referrals (Recodified)
140.911	Basic Rehabilitation Aide Training Program (Recodified)
140.912	Interim Nursing Rates (Recodified)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section	
140.920	General Description
140.922	Covered Services
140.924	Maternal and Child Health Provider Participation Requirements
140.926	Client Eligibility (Repealed)
140.928	Client Enrollment and Program Components (Repealed)
140.930	Reimbursement

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140.932 Payment Authorization for Referrals (Repealed)

SUBPART H: ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM

Section

140.940 Illinois Competitive Access and Reimbursement Equity (ICARE) Program (Recodified)
140.942 Definition of Terms (Recodified)
140.944 Notification of Negotiations (Recodified)
140.946 Hospital Participation in ICARE Program Negotiations (Recodified)
140.948 Negotiation Procedures (Recodified)
140.950 Factors Considered in Awarding ICARE Contracts (Recodified)
140.952 Closing an ICARE Area (Recodified)
140.954 Administrative Review (Recodified)
140.956 Payments to Contracting Hospitals (Recodified)
140.958 Admitting and Clinical Privileges (Recodified)
140.960 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Recodified)
140.962 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Recodified)
140.964 Contract Monitoring (Recodified)
140.966 Transfer of Recipients (Recodified)
140.968 Validity of Contracts (Recodified)
140.970 Termination of ICARE Contracts (Recodified)
140.972 Hospital Services Procurement Advisory Board (Recodified)
140.980 Elimination Of Aid To The Medically Indigent (AMI) Program (Emergency Expired)
140.982 Elimination Of Hospital Services For Persons Age Eighteen (18) And Older And Persons Married And Living With Spouse, Regardless Of Age (Emergency Expired)

SUBPART I: PRIMARY CARE CASE MANAGEMENT PROGRAM

Section

140.990 Primary Care Case Management Program
140.991 Primary Care Provider Participation Requirements
140.992 Populations Eligible to Participate in the Primary Care Case Management Program
140.993 Care Management Fees

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- 140.994 Panel Size and Affiliated Providers
- 140.995 Mandatory Enrollment
- 140.996 Access to Health Care Services
- 140.997 Payment for Services

SUBPART J: ALTERNATE PAYEE PARTICIPATION

Section

- 140.1001 Registration Conditions for Alternate Payees
- 140.1002 Participation Requirements for Alternate Payees
- 140.1003 Recovery of Money for Alternate Payees
- 140.1004 Conditional Registration for Alternate Payees
- 140.1005 Revocation of an Alternate Payee

SUBPART K: MANDATORY MCO ENROLLMENT

- 140.1010 Mandatory Enrollment in MCOs

SUBPART L: UNAUTHORIZED USE OF MEDICAL ASSISTANCE

Section

- 140.1300 Definitions
- 140.1310 Recovery of Money
- 140.1320 Penalties
- 140.1330 Enforcement

- 140.TABLE A Criteria for Non-Emergency Ambulance Transportation
- 140.TABLE B Geographic Areas
- 140.TABLE C Capital Cost Areas
- 140.TABLE D Schedule of Dental Procedures
- 140.TABLE E Time Limits for Processing of Prior Approval Requests
- 140.TABLE F Podiatry Service Schedule (Repealed)
- 140.TABLE G Travel Distance Standards
- 140.TABLE H Areas of Major Life Activity
- 140.TABLE I Staff Time and Allocation for Training Programs (Recodified)
- 140.TABLE J ~~Rate Regions HSA Grouping (Repealed)~~
- 140.TABLE K Services Qualifying for 10% Add-On (Repealed)
- 140.TABLE L Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)
- 140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services (Repealed)

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AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; preemptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; preemptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; preemptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; preemptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended

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at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended

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at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1,

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1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December

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19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25

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Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a

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maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; preemptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; preemptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill. Reg. 18323, effective November 12, 2008; preemptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; preemptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009; emergency amendment at 33 Ill. Reg. 10800, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 11287, effective July 14, 2009; amended at 33 Ill. Reg. 11938, effective August 17, 2009; amended at 33 Ill. Reg. 12227, effective October 1, 2009; emergency amendment at 33 Ill. Reg. 14324, effective October 1, 2009, for a maximum of 150 days; emergency expired February 27, 2010; amended at 33 Ill. Reg. 16573, effective November 16, 2009; amended at 34 Ill. Reg. 516, effective January 1, 2010; amended at 34 Ill. Reg. 903, effective January 29, 2010; amended at 34 Ill. Reg. 3761, effective March 14, 2010; amended at 34 Ill. Reg. 5215, effective March 25, 2010; amended at 34 Ill. Reg. 19517, effective December 6, 2010; amended at 35 Ill. Reg. 394, effective December 27, 2010; amended at 35 Ill. Reg. 7648, effective May 1, 2011; amended at 35 Ill. Reg. 7962, effective May 1, 2011;

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amended at 35 Ill. Reg. 10000, effective June 15, 2011; amended at 35 Ill. Reg. 12909, effective July 25, 2011; amended at 36 Ill. Reg. 2271, effective February 1, 2012; amended at 36 Ill. Reg. 7010, effective April 27, 2012; amended at 36 Ill. Reg. 7545, effective May 7, 2012; amended at 36 Ill. Reg. 9113, effective June 11, 2012; emergency amendment at 36 Ill. Reg. 11329, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 140.442(e)(4) suspended at 36 Ill. Reg. 13736, effective August 15, 2012; suspension withdrawn from Section 140.442(e)(4) at 36 Ill. Reg. 14529, September 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.442(e)(4) at 36 Ill. Reg. 14820, effective September 21, 2012 through June 30, 2013; emergency amendment to Section 140.491 suspended at 36 Ill. Reg. 13738, effective August 15, 2012; suspension withdrawn by the Joint Committee on Administrative Rules from Section 140.491 at 37 Ill. Reg. 890, January 8, 2013; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.491 at 37 Ill. Reg. 1330, effective January 15, 2013 through June 30, 2013; amended at 36 Ill. Reg. 15361, effective October 15, 2012; emergency amendment at 37 Ill. Reg. 253, effective January 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 846, effective January 9, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 1774, effective January 28, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 2348, effective February 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 3831, effective March 13, 2013; emergency amendment at 37 Ill. Reg. 5058, effective April 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 5170, effective April 8, 2013 through June 30, 2013; amended at 37 Ill. Reg. 6196, effective April 29, 2013; amended at 37 Ill. Reg. 7985, effective May 29, 2013; amended at 37 Ill. Reg. 10282, effective June 27, 2013; amended at 37 Ill. Reg. 12855, effective July 24, 2013; emergency amendment at 37 Ill. Reg. 14196, effective August 20, 2013, for a maximum of 150 days; amended at 37 Ill. Reg. 17584, effective October 23, 2013; amended at 37 Ill. Reg. 18275, effective November 4, 2013; amended at 37 Ill. Reg. 20339, effective December 9, 2013; amended at 38 Ill. Reg. 859, effective December 23, 2013; emergency amendment at 38 Ill. Reg. 1174, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. _____, effective January 29, 2014; amended at 38 Ill. Reg. _____, effective _____.

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section 140.11 Enrollment Conditions for Medical Providers

- a) In order to enroll for participation, providers shall:
 - 1) Hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical vendors.;

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- 2) Be certified for participation in the Title XVIII Medicare program where federal or State rules and regulations require such certification for Title XIX participation. ~~;~~
 - 3) Be certified for Title XIX when federal or State rules and regulations so require. ~~;~~
 - 4) Provide enrollment information to the Department in the prescribed format, and notify the Department, in writing, immediately whenever there is a change in any such information which the provider has previously submitted. ~~;~~
 - 5) Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to public aid recipients. ~~;~~ ~~and~~
 - 6) Have a written provider agreement on file with the Department.
- b) Approval of a corporate entity such as a pharmacy, laboratory, durable medical equipment and supplies provider, medical transportation provider, nursing home or renal satellite facility, as a participant in the Medical Assistance Program, applies only to the entity's existing ownership, corporate structure and location; therefore, participation approval is not transferable.
 - c) Except for children's hospitals described at 89 Ill. Adm. Code ~~148.25(d)(3)(B)149.50(e)(3)~~, hospitals providing inpatient care that are certified under a single Centers for Medicare and Medicaid Services certification Medicare number shall be enrolled as a single an individual entity in the Medical Assistance Program. A children's hospital must be separately enrolled from the general care hospital with which it is affiliated.
 - d) Upon notification from the Illinois Department of Public Health of a change of ownership, the Department shall notify the prospective buyer of its obligation under Section 140.12(l) to assume liability for repayment to the Department for overpayments made to the current owner or operator. Such notification shall inform the prospective buyer of all outstanding known liabilities due to the Department by the facility and of any known pending Department actions against the facility that may result in further liability. For long term care providers, when

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there is a change of ownership of a facility or a facility is leased to a new operator, the provider agreement shall be automatically assigned to the new owner or lessee. Such assigned agreement shall be subject to all conditions under which it was originally issued, including, but not limited to, any existing plans of correction, all requirements of participation as set forth in Section 140.12 or additional requirements imposed by the Department.

- e) For purposes of administrative efficiency, the Department may periodically require classes of providers to re-enroll in the Medical Assistance Program. Under such re-enrollments, the Department shall request classes of providers to submit updated enrollment information. Failure of a provider to submit such information within the requested time frames will result in the ~~disenrollment~~~~dis-enrollment~~ of the provider from the Program. Such ~~disenrollment~~~~dis-enrollment~~ shall have no effect on the future eligibility of the provider to participate in the Program and is intended only for purposes of the Department's efficient administration of the Program. A ~~disenrolled~~~~dis-enrolled~~ provider may reapply to the Program and all such re-applications must meet the requirements for enrollment.
- f) For purposes of this Section, a vendor whose investor ownership has changed by 50 percent or more from the date the vendor was initially approved for enrollment in the Medical Assistance Program shall be required to submit a new application for enrollment in the Medical Assistance Program. All such applications must meet the requirements for enrollment.
- g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a vendor is subject to a provisional period and shall be conditional for one year unless limited by the Department. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the Medical Assistance Program without cause. Upon termination of a vendor under this subsection (g), the following individuals shall be barred from participation in the Medical Assistance Program:
 - 1) ~~Individuals~~~~individuals~~ with management responsibility;
 - 2) ~~All~~~~all~~ owners or partners in a partnership;
 - 3) ~~All~~~~all~~ officers of a corporation or individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership in a corporation; or

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- 4) ~~Anan~~ owner of a sole proprietorship.
- h) Unless otherwise specified, the termination of eligibility or vendor disenrollment, as described in subsection (g) of this Section, and resulting amendments are not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.16 Termination, Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program

- a) ~~The Effective July 1, 2012, the~~ Department may terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, terminate or not renew a vendor's provider agreement, or exclude a person or entity from participation in the Medical Assistance Program, when it determines that, at any time:
 - 1) The vendor is not complying with the Department's policy or rules, or with the terms and conditions prescribed by the Department in any vendor agreement developed as a result of negotiations with the vendor category, or with the covenants contained in certifications bearing the vendor's signature on claims submitted to the Department by the vendor, or with restrictions on participation imposed pursuant to Section 140.32~~(f)~~;
 - 2) The vendor, person or entity is not properly licensed, certified, authorized or otherwise qualified, or the vendor person's or entity's professional license, certificate or other authorization has not been renewed or has been restricted, revoked, suspended or otherwise terminated as determined by the appropriate licensing, certifying or authorizing agency. The termination, suspension or exclusion shall be immediately effective;
 - 3) The vendor violates records requirements as set forth in statute or Department rules, provider handbooks or policies.
 - A) The vendor has failed to keep or timely make available for inspection, audit or copying (including photocopying), after receiving a written request from the Department:

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- i) records required to be maintained by the Department or necessary to fully and completely disclose the extent of the services or supplies provided; or
 - ii) full and complete records required to be maintained by the Department regarding payments claimed for providing services.
- B) This subsection (a)(3) does not require vendors to make available medical records of patients for whom services are not reimbursed under the Illinois Public Aid Code;
- 4) The vendor has failed to furnish any information requested by the Department regarding payments for providing goods or services, or has failed to furnish all information required by the Department in connection with the rendering of services or supplies to recipients of public assistance by the vendor or his or her agent, employer or employee;
- 5) The vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Medical Assistance Program. For purposes of this subsection (a)(5), statements or representations made "knowingly" shall include statements or representations made with actual knowledge that they were false as well as those statements made when the individual making the statement had knowledge of such facts or information as would cause one to be aware that the statements or representations were false when made;
- 6) The vendor has submitted claims for services or supplies that were not rendered or delivered by that vendor;
- 7) The vendor has furnished goods or services to a recipient that, when based upon competent medical judgment and evaluation, are determined to be:
 - A) in excess of needs;
 - B) harmful (for the purpose of this subsection (a)(7)(B), "harmful" goods or services cause actual harm as defined in Section 140.13 or place an individual at risk of harm, or of adverse side effects, that outweigh the medical benefits sought); or

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- C) of grossly inferior quality;
- 8) The vendor knew or should have known that a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an investor in the vendor, a technical or other advisor of the vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor was previously terminated, suspended, excluded or barred from participation in the Medical Assistance Program, or in another state or federal medical assistance or health care program;
- 9) The vendor has a delinquent debt owed to the Department;
- 10) The vendor engaged in practices prohibited by federal or State law or regulation.
 - A) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor, either:
 - i) has engaged in practices prohibited by applicable federal or State law or regulation; or
 - ii) was a person with management responsibility for a vendor at the time that the vendor engaged in practices prohibited by applicable federal or State law or regulation; or
 - iii) was an officer, or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a vendor at the time the vendor engaged in practices prohibited by applicable federal or State law or regulation; or
 - iv) was an owner of a sole proprietorship or partner of a partnership that was a vendor at the time the vendor

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engaged in practices prohibited by applicable federal or State law or regulation;

- B) For purposes of this subsection (a)(10), "applicable federal or State law or regulation" includes, but is not limited to, licensing or certification standards contained in State or federal law or regulations related to the Medical Assistance Program, any other licensing standards as they relate to the vendor's practice or business or any federal or State laws or regulations related to the Medical Assistance Program;
 - C) For purposes of this subsection (a)(10), conviction or a plea of guilty to activities violative of applicable federal or State law or regulation shall be conclusive proof that those activities were engaged in;
- 11) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor has been convicted in this or any other State, or in any Federal Court, of any offense not related to the Medical Assistance Program, if the offense constitutes grounds for disciplinary action under the licensing Act applicable to that individual or vendor;
- 12) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or partner in a partnership that is a vendor has been convicted in this or any other state, or in any Federal Court, of:
- A) murder;
 - B) a Class X felony under the Illinois Criminal Code of 1961;
 - C) sexual misconduct that may subject recipients to an undue risk of harm;

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- D) a criminal offense that may subject recipients to an undue risk of harm;
 - E) a crime of fraud or dishonesty;
 - F) a crime involving a controlled substance;
 - G) a misdemeanor relating to fraud, theft, embezzlement or breach of fiduciary responsibility; or
 - H) other financial misconduct related to a health care program.
- 13) The direct or indirect ownership of the terminated, suspended or excluded vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) has been transferred by an individual to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage.
- b) The Department may suspend a vendor's eligibility to participate in the Medical Assistance Program if the vendor is not in compliance with State income tax requirements, child support payments in accordance with Article X of the [Illinois Public Aid Code](#), or educational loans guaranteed by the Illinois Student Assistance Commission. The vendor may prevent suspension of eligibility by payment of past-due amounts in full or by entering into payment arrangements acceptable to the appropriate State agency.
 - c) ~~The Effective July 1, 2012, the~~ Department may terminate, suspend or exclude vendors who pose a risk of fraud, waste, abuse or harm, as defined in Section 140.13, from participation in the Medical Assistance Program.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments

- a) C-13 Invoice Voucher Advance Payments

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- 1) The C-13 invoice voucher, when used as an advanced payment, is an exception to the regular reimbursement process. It may be issued only under extraordinary circumstances to qualified providers of medical assistance services. C-13 advance payments will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:
 - A) are enrolled with the Department ~~of Public Aid~~;
 - B) have experienced an emergency which necessitates C-13 advance payments. Emergency in this instance is defined as a circumstance under which withholding of the advance payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
 - i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired; or
 - ii) cash flow problems encountered by a provider or group of providers which are unrelated to agency technical system problems. These situations include problems which are exclusively those of the providers or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider, adversely impacting on the ability to promptly serve the clients;
 - C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:
 - i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;
 - ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

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- iii) for hospitals, the hospital must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;
 - iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;
 - v) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;
 - vi) for government-owned facilities, this subsection (a)(1)(C) may be waived if the cash flow ~~criteria~~criteria under subsection (a)(1)(B)(ii) is met; and
 - vii) for providers who have filed for Chapter 11 bankruptcy, this subsection (a)(1)(C) may be waived if the cash flow ~~criteria~~criteria under subsection (a)(1)(B)(ii) are met;
- D) sign an agreement with the Department which specifies the terms of advance payment and subsequent repayment. The agreement will contain the following provisions:
- i) specific reason(s) for advanced payments;
 - ii) specific amount agreed to be advanced;
 - iii) specific date to begin recoupment; and
 - iv) method of recoupment (percentage of payable amount of each Medicaid Management Information System (MMIS) voucher, specific amount per month, a warrant intercept, or a combination of the three recovery methods).
- 2) Determination of amount of payment to be issued shall be based on anticipated future payments as determined by the Department.
- 3) Approval Process

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- A) In order to obtain C-13 advance payments, providers must submit their request in writing (~~telefacsimile and email telefax~~ requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:
- i) an explanation of the circumstances creating the need for the advance payments;
 - ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and
 - iii) specification of the amount of the advance required.
- B) An agreement will be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to release of the warrant.
- C) C-13 advance payments shall be authorized for the provider following approval by the ~~Medicaid~~ Administrator of the Division of Medical Programs or designee. Once all requirements of this subsection (a)(3) are met, the Administrator will authorize payment within seven days.
- 4) Recoupment
- A) Health care entities other than individual practitioners shall be required to sign an agreement stating that, should the entity be sold, the new owners will be made aware of the liability and will assume responsibility for repaying the debt to the Department according to the original agreement.
 - B) All providers shall sign an agreement specifying the terms of recoupment. An agreed percentage of the total payment to the provider for services rendered shall be deducted from future payments until the debt is repaid. For providers who are properly certified, licensed or otherwise qualified under appropriate State and federal requirements, the recoupment period shall not exceed six months from the month in which payment is authorized. For

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those providers enrolled but not in good standing (e.g., decertification termination hearing or other adverse action is pending), recoupment will be made from the next available payments owed the provider.

- C) In the event that the provider fails to comply with the recoupment terms of the agreement, the remaining balance of any advance payment shall be immediately recouped from claims being processed by the Department. If such claims are insufficient for complete recovery, the remaining balance will become immediately due and payable by check to the Illinois Department of Public Aid. Failure by the provider to remit such check will result in the Department pursuing other collection methods.

5) Prior Agreements

The terms of any agreement signed between the provider and the Department prior to the adoption of this [Section or prior to any amendment to this Section](#) ~~rule~~ will remain in effect, notwithstanding the provisions of this Section .

b) Expedited Claims Payments

- 1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital [qualified and participating under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act \[210 ILCS 155\]](#), a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

- A) are enrolled with the Department ~~of Public Aid~~;
- B) have experienced an emergency which necessitates expedited payments. Emergency in this instance is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. Circumstances

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which may create such emergencies include, but are not limited to, the following:

- i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to the clients is severely impaired;
- ii) cash flow problems encountered by a provider or group of providers which are unrelated to Department technical system problems. These situations include problems which are exclusively those of the providers (i.e., provider billing system problems) or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider adversely impacting on the ability to serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

- i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;
- ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;
- iii) for hospitals, the hospitals must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;
- iv) ~~for hospitals that qualify as disproportionate share hospitals as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122 and receive Rehabilitation Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(b)) or Direct Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(e)(1)), a request must be made in writing that demonstrates proof of cash flow problems;~~

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- ~~iv~~) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;
 - ~~v~~) for sole source pharmacies in a community that are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;
 - ~~vi~~) for government-owned facilities, this subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) are met; and
 - ~~vii~~) for providers who have filed for Chapter 11 bankruptcy, subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (b)(1)(B)(ii) are met.
- 2) Reimbursement will be based upon the amount of claims determined payable and be made for a period specified by the Department.
- 3) Approval Process
- A) In order to qualify for expedited payments, providers must submit their request in writing (~~telefacsimile and email~~~~telefax~~ requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:
 - i) an explanation of the need for the expedited payments; and
 - ii) supportive documentation to substantiate the emergency nature of the request.
 - B) Expedited payments shall be authorized for the provider following approval by the ~~Medicaid~~-Administrator of the Division of Medical Programs or designee.
 - C) The Department will periodically review the need for any continued expedited payments.
- 4) Prior Agreements

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The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section ~~rule~~ will remain in effect, notwithstanding the provisions of this Section .

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.402 Copayments for Non-institutional Medical Services

The following implements cost sharing in compliance with 42 USC 1396o (section 1916 of the Social Security Act):

- a) ~~Each Effective July 1, 2012, each~~ recipient, with the exception of those classes of recipients identified in subsection (d) of this Section, shall be required to pay a copayment of \$2.00 for generic legend drugs and over-the-counter drugs billed to the Department, and for other services, with the exception of those services identified in subsection (e), the nominal copayment amount as defined at 42 CFR 447.54. For dates of service beginning July 1, 2012 through March 31, 2013 the nominal copayment amount is \$3.65. Beginning with dates of service on April 1, 2013, the nominal copayment amount is \$3.90. Specific copayment amounts are described and updated on the Department's Web site for the following non-institutional medical services:
- 1) Office visits to enrolled practitioners for services reimbursed under the Illinois Public Aid Code.
 - 2) Each brand name legend drug billed to the Department.
 - 3) Each encounter billed to the Department by an Encounter Rate Clinic (ERC), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), but excluding behavioral services provided by these facilities. For dates of service beginning July 1, 2013, copayments for behavioral health services provided by these facilities are no longer excluded and shall be required to be paid by recipients with the exception of those classes of recipients identified in subsection (d).

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- b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the respective amount of the required copayment.
- c) No provider of services listed in subsection (a) may deny service to an individual who is eligible for service on account of the individual's inability to pay the cost of a copayment.
- d) The following individuals receiving medical assistance are exempt from the copayment requirement set forth in subsection (a):
 - 1) Pregnant women, including a postpartum period of 60 days.
 - 2) Children under 19 years of age.
 - 3) All non-institutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections.
 - 4) Hospice patients.
 - 5) Individuals residing in hospitals, nursing facilities, and intermediate care facilities for the developmentally disabled who, as a condition of receiving services, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their care. For the purpose of this subsection (d)(5), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).
 - 6) Residents of a State-certified, State-licensed, or State-contracted residential care program where residents, as a condition of receiving care in that program, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their residential care program. For the purpose of this subsection (d)(6), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).
 - 7) Individuals enrolled in the "Health Benefits for Person with Breast or Cervical Cancer" program under 89 Ill. Adm. Code 120.500.

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- 8) American Indians or Alaskan Natives.
- e) The following medical services are exempt from any copayments:
 - 1) Renal dialysis treatment.
 - 2) Radiation therapy.
 - 3) Cancer chemotherapy.
 - 4) Insulin.
 - 5) Services for which Medicare is the primary payer.
 - 6) Emergency services as defined at 42 USC 1396u-2(b)(2) (section 1932(b)(2) of the Social Security Act) and 42 CFR 438.114(a).
 - 7) Any pharmacy compounded drugs.
 - 8) Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.
 - 9) Family planning services and supplies described in 42 USC 1396d(a)(4)(C) (section 1905(a)(4)(C) of the Social Security Act), including contraceptives and other pharmaceuticals for which the State claims or could claim federal ~~financial participation match~~ at the enhanced rate under 42 USC 1396b(a)(5) (section 1903(a)(5) of the Social Security Act) for family planning services and supplies.
 - 10) Other therapeutic drug classes as specified by the Department.
 - 11) Preventive services as described in section 4106(b) of the Affordable Care Act.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.459 Payment for Therapy Services

- a) Therapy services shall be paid at an all-inclusive ~~per half hour~~ rate which shall be the lower of:

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- 1a) The providers usual and customary charge for services, ~~of~~
- 2b) The maximum reimbursement rate established by the Department.
- b) Maximum reimbursement rates. The maximum reimbursement rate:
 - 1) For outpatient physical rehabilitation services provided by a hospital – paid per visit and limited to one visit per day:
 - A) That is a children’s hospital, as defined in paragraph 148.25(d)(3)(A), enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.
 - B) Enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.
 - C) Not enrolled with the Department to provide outpatient physical rehabilitation shall be \$115.00.
 - 2) For all other therapy services – paid per quarter hour, shall be as published in fee schedules on the Department’s website.

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(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.461 Clinic Participation, Data and Certification Requirements

- a) Hospital-based organized clinics must:
 - 1) Have an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care. ~~;~~
 - 2) Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the Department, for the acquisition of these services through contractual arrangements with external medical providers. ~~;~~
 - 3) Meet one of the following requirements:
 - A) Be adjacent to or on the premises of a the hospital and be

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- i) licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or
 - ii) that meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.
- B) ~~Have~~have provider-based status under Medicare pursuant to 42 CFR 413.65. ~~or~~
- C) ~~Be~~clinically integrated as evidenced by all of the following:
 - i) ~~Professional~~ professional staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system of the main hospital, or cross reference that retrieval system; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred when appropriate to the corresponding inpatient or outpatient department or service of the main hospital. ~~and~~
 - ii) ~~Fully~~ fully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic. ~~and~~
 - iii) ~~Held~~ held out to the public and other payers as part of the main hospital. ~~and~~
 - iv) ~~Operated~~ operated under the ownership and control of the main hospital, as evidenced by the following: the business

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enterprise that constitutes the clinic is 100 percent owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the clinic. ~~and~~

- v) ~~Located~~ located within a 35 mile radius of the main hospital campus as defined in 42 CFR 413.65.
- 4) Meet the applicable requirements of 89 Ill. Adm. Code 148.40(d).
- b) Encounter rate clinics must ~~(i) have participated-participate~~ in the Medical Assistance Program as an encounter rate clinic as of July 1, 1998, or (ii) be a clinic operated by ~~an Illinois-a~~ county with a population of over three million. Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities. In order to participate in the Maternal and Child Health Program, as described in Subpart G, encounter rate clinics shall be required to meet the additional participation requirements described in Section 140.924(a)(2).
 - c) Rural health clinics must be certified by the Centers for Medicare and Medicaid Services, Health Care Financing Administration ~~as~~ meeting the requirements for Medicare participation.
 - d) Federally Qualified Health Centers (FQHC):
 - 1) Must meet one of the following criteria ~~be Health Centers which~~:
 - A) Receive ~~receive~~ a grant under Section 329, 330 or 340 of the Public Health Service Act (42 USC 329, 330, 340) ~~or~~
 - B) Based ~~based~~ on the recommendation of the Health Resources and Services Administration within the U.S. Department of Health and Human Services ~~Public Health Service~~, are determined to meet the requirements for receiving such a grant.

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- 2) ~~Section 4602 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which amended~~ Section 1902(a)(55) of the Social Security Act (42 USC ~~Section~~ 1396a(a)(55)), requires states to receive and initially process Medicaid applications from low-income pregnant women and children under 19 years of age at locations other than the local Department of Human Services (DHS) office. Such a site is referred to as an outstation.
- A) Outstations will be located at those FQHCs which the Department determines serve heavy Medicaid populated areas. For areas in which the Department determines that maintaining outstation workers is not economical, the DHS Family Community Resource Center (FCRC) ~~local office~~ will continue to be the application location.
- B) The FQHCs, which will provide outstation eligibility staff to accept and assist in the initial processing of the Medicaid application for pregnant women and children, will forward the completed application to the appropriate DHS FCRC local office. Initial processing means accepting and completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete and conducting any necessary interviews. Neither the FQHCs nor the outstation workers will evaluate the information contained on the application, nor make any determination of eligibility or ineligibility. The DHS FCRC ~~local office~~ is responsible for these functions.
- C) Costs allowable under the federal outstation mandate for completing the Medicaid application will be itemized in Section B of Schedule I of the FQHC Medicaid cost report and will be provided annually in the FQHC cost reporting process. These allowable costs will be collected, computed and calculated, and will result in the establishment of an outstation administrative rate and a Medicaid rate. The allowable costs are:
- i) Salary of outstation worker.;
- ii) Fringe benefits.;

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- iii) Training.
 - iv) Travel. ~~and~~
 - v) Supplies.
- D) FQHC outstation workers must receive certification through Maternal and Child Health (MCH) process training by the Department before they begin to perform eligibility processing functions. Failure to become certified results in any MCH application completed by an ineligible worker being non-allowed on the cost report.
- E) FQHCs must have adequate staff trained with proper backup to accommodate unforeseen problems. FQHCs must be able to meet the demand of this initiative, either using staff at one location or rotating staff as dictated by workload or staffing availability. The FQHC must have staff available at each outstation location during regular office operating hours.
- F) Outstation intake staff may perform other FQHC intake processing functions, but the time spent on outstation activities must be documented and must be identifiable for cost reporting and auditing purposes.
- G) The FQHC must display a notice in a prominent place at the outstation location advising potential applicants of the times that outstation intake workers will be available. The notice must include a telephone number that applicants may call for assistance.
- H) The FQHC must comply with federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.
- e) Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities.
- f) ~~Maternal and Child Health Clinics~~

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4) Types of Clinics

The following clinics shall qualify as Maternal and Child Health Clinics:

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A) ~~Certified Hospital Ambulatory Primary Care Centers (CHAPCC) that are hospital-based organized outpatient clinics, as described in subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide ambulatory primary care to Medicaid children from birth through 20 years of age, and pregnant women in a non-emergency room setting. At least 50 percent of all staff physicians providing care in a CHAPCC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHAPCC must be for primary care.~~

B) ~~Certified Hospital Organized Satellite Clinics (CHOSC) that are clinics meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that are owned, operated, and/or managed by a hospital but do not qualify as hospital-based organized clinics, as described in subsection (a), because they are not located adjacent to or on the premises of the hospital or are not licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. Through staff and supporting resources, these clinics provide ambulatory primary care in a non-emergency setting to Medicaid children from birth through 20 years of age, and to pregnant women. At least 50 percent of all staff physicians providing care in a CHOSC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHOSC must be for primary care. Primary care consists of basic health services provided by a physician or other qualified medical professional to maintain the day-to-day health status of a patient, without requiring the level of medical technology and specialized expertise necessary for the provision of secondary and tertiary care. CHOSCs shall meet the requirements in subsections (a)(1) and (a)(2).~~

C) ~~Certified Obstetrical Ambulatory Care Centers (COBACC) that are hospital-based organized clinic entities, as described in subsection~~

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~~(a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide primary care and specialty services to Medicaid-eligible pregnant women, especially those determined to be non-compliant or at high risk, in an outpatient setting.~~

~~D) Certified Pediatric Ambulatory Care Centers (CPACC) that are hospital-based organized clinic entities, as described in subsection (a), owned and operated by a hospital as described in 89 Ill. Adm. Code 149.50(e)(3), and meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide pediatric primary care and specialty services as described in Section 140.462(e)(3)(C) to Medicaid-enrolled children with specialty needs, from birth through 20 years of age in an outpatient setting. Hospitals with CPACCs must also provide primary care for at least 1,500 children, either through its CPACC or through a CHAPCC, CHOSC or encounter rate clinic operated by the same hospital. Hospitals unable to meet this volume requirement must agree to serve as a specialty-referral site for another hospital operating a CPACC through a written agreement submitted to the Department.~~

~~2) General Participation Requirements
In addition to the Maternal and Child Health participation requirements described in Section 140.924(a)(1), the Maternal and Child Health clinics identified in subsection (f)(1) must:~~

~~A) Be operated by a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120, be staffed by board certified/eligible physicians who have hospital admitting and/or delivery privileges, be operated by a hospital in an organized corporate network of hospitals having a total of more than 1,000 staffed beds, and agree to provide care for a minimum of 100 pregnant women or children; or be a primary care teaching site of an organized academic department of:~~

~~i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), a pediatric or family practice residency program~~

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- ~~accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information.~~
- ~~ii) In the case of clinics described in subsection (f)(1)(C), an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~
- ~~iii) In the case of clinics described in subsection (f)(1)(D), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~
- ~~B) Under the direction of a board-certified/eligible physician who has hospital admitting and/or delivery privileges and provides direct supervision to residents practicing in the certified ambulatory site, provide:~~
- ~~i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), primary care.~~
- ~~ii) In the case of clinics described in subsection (f)(1)(C), obstetric and specialty services.~~
- ~~iii) In the case of clinics described in subsection (f)(1)(D), primary care and specialty services.~~
- ~~C) Maintain a formal, ongoing quality assurance program that meets the minimum standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO);~~
- ~~D) Provide historical evidence of fiscal solvency and financial projections for the future, in a manner specified by the Department; and~~

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~~E) Utilize a formal client tracking and care management system that affords timely maintenance of, access to, and continuity of medical records without compromising client confidentiality.~~

~~3) Special Participation Requirements
In addition to the Maternal and Child Health provider participation requirements described in Section 140.924(a)(1), and the general participation requirements described in subsection (f)(2), special participation requirements shall apply as follows:~~

~~A) Clinics described in subsections (f)(1)(A) and (f)(1)(B) must:~~

- ~~i) Serve a total population that includes at least 20 percent Medicaid and medically indigent clients;~~
- ~~ii) Perform a risk assessment on pregnant women assigned to them in order to determine if the woman is at high risk; and~~
- ~~iii) Provide or arrange for specialty services when needed by pregnant women or children.~~

~~B) Clinics described in subsection (f)(1)(C) must:~~

- ~~i) Be a distinct department of a hospital that also operates as a Level II, Level II with Extended Neonatal Capabilities or Level III perinatal center;~~
- ~~ii) Provide services to pregnant women demonstrating the need for extensive health care services due to complicated medical conditions placing them potentially at high risk of abnormal delivery, including substance abuse or addiction problems. Hospital clinics will not qualify to participate unless they provide both primary and specialty services to women who currently are Medicaid clients, or Medicaid-eligible women who receive services at the COBACC; in this capacity, COBACCs, as perinatal centers, shall serve pregnant women determined to be at high risk of abnormal delivery;~~

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- iii) ~~Operate a designated 24-hour per day emergency referral site with a defined practice for the care of obstetric emergencies;~~
 - iv) ~~Have an established program of services for the treatment of substance-abusing pregnant women;~~
 - v) ~~Integrate an accredited obstetrical residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved high-risk pregnant women; and~~
 - vi) ~~Operate organized ambulatory clinics for pregnant women that are easily accessible to the medically underserved.~~
- C) ~~Clinics described in subsection (f)(1)(D) must:~~
- i) ~~Provide primary and specialty services for children demonstrating the need for extensive health care services due to a chronic condition as described in Section 140.462(e)(3)(C);~~
 - ii) ~~Operate a designated 24-hour per day emergency referral site with a defined practice for the care of pediatric emergencies;~~
 - iii) ~~Provide access to necessary pediatric primary and specialty services within 24 hours after referral;~~
 - iv) ~~Be a distinct department of a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120(a)(5);~~
 - v) ~~Integrate an accredited pediatric or family practice residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved children with specialty needs; and~~

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~~vi) Operate organized ambulatory clinics for children that are easily accessible to the medically underserved.~~

~~4) Data Requirements~~

~~The Maternal and Child Health clinics described in subsection (f)(1) shall be required to submit patient level historical data to the Department, which may include, but shall not be limited to historical data on the use of the hospital emergency room department.~~

~~5) Certification Requirements~~

~~Certification of qualifying status of a Maternal and Child Health clinic identified in subsection (f)(1) shall occur annually during the first two years of participation and every other year thereafter. In addition:~~

~~A) The certification process shall consist of a review of the completed application and related materials to determine provisional certification status. Those centers submitting approved applications shall then be reviewed on site by Department staff within 60 days after application approval. Final notification of certification status shall be rendered within 30 days after the site review, pending provider submittal of a written plan of correction for any deficiencies discovered during the entire application process.~~

~~B) Entities interested in becoming a Maternal and Child Health clinic must direct a written request for an application packet to the following address:~~

~~Maternal and Child Health Clinic Certification
Bureau of Comprehensive Health Services
Illinois Department of Public Aid
201 South Grand Avenue East, Concourse
Springfield, Illinois 62763-0001~~

~~C) Certification status shall be suspended for Maternal and Child Health clinics identified in subsection (f)(1) that do not submit data to the Department, as required under subsection (f)(4), within 180 days after the Department's request for the submittal of such data.~~

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- (e) School Based/Linked Health Clinics (centers) must be certified by the Department of Human Services (DHS) that they are meeting the minimum standards established by DHS (77 Ill. Adm. Code 2200). Examples of certification requirements include:
- 1) School based health centers must be located in schools or on school grounds, serving at least the students attending that school.
 - 2) School linked health centers are located off school grounds, but a formal relationship must exist to serve students attending a particular school or multiple schools within the district.
 - 3) All medical services performed by mid-level practitioners (i.e., medical services providers who are not physicians), such as nurse practitioners (~~see Section 140.400~~), must be under the direction of a physician.
 - 4) The center must have a medical director. The medical director of the center must be a qualified physician, licensed in Illinois to practice medicine in all its branches. Each center's medical director must develop standing orders and protocols for services provided at the center. The medical director shall ensure compliance with the policies and procedures pertaining to medical procedures and health care services. The medical director shall supervise the medical protocols involving direct care of students. The center must have consultant or back-up physicians with hospital admitting privileges. The consultant provider of the clinic for obstetrical care, as appropriate, must have delivery privileges. All medical services must be delivered in accordance with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice Guidelines and the standards established by outside regulatory agencies.
 - 5) All laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (42 USC 263a). DHS will provide ongoing monitoring to assure that appropriate standards are followed.
 - 6) The center shall be staffed by Illinois licensed, registered, and/or certified health professionals who are trained and experienced in community and school health, and who have knowledge of health promotion and illness prevention strategies for children and adolescents. The center must ensure

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that staff are assigned responsibilities consistent with their education and experience, supervised, evaluated annually and trained in the policies and procedures of the center.

- 7) The center must establish procedures for the availability of primary care providers and for 24-hour per day, 12-month per year access to routine, urgent and emergency care, telephone appointments and advice. The center must have in place telephone answering methods that notify students and parents/guardians where and how to access 24-hour back-up services when the center is not open.
- 8) Services may be provided to eligible students who have obtained written parental consent, or who are 18 years of age, and/or who are otherwise able to give their own consent.
- 9) The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and/or parental consent to share information regarding a student's health care.
- 10) The center must operate in accordance with a systematic process for referring students to community-based health care providers when the center is not able to provide the services required by the student. The center may provide medical care to a Managed Care Entity (MCE) enrolled student. The center shall refer that MCE enrolled student to the MCE primary care provider for continuing and definitive care.
 - A) The center shall refer a student who requires specialty medical and/or surgical services to his or her primary care provider or MCE to obtain a referral for a specialist.
 - B) The center shall document in the student's record that the referral was made, and document follow-up on the outcome of the referral when relevant to the health care provided by the center.
- 11) The center must develop a collaborative relationship with other health care providers, insurers, managed care organizations, the school health program, students and parents or guardians with the goal of assuring

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continuity of care, pertinent medical record sharing and reducing duplication and fragmentation of services.

- 12) Data Requirements
The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

~~gh~~) Hospital Outpatient Departments
Hospital outpatient departments may include facilities that meet the requirements of subsection (a)(3) of this Section.

~~h~~) County-operated outpatient facilities. A county-operated outpatient facility is a non-hospital-based clinic operated by and located in an Illinois county with a population exceeding three million.

1) Critical Clinic Providers. A critical clinic provider is a county-operated outpatient facility, that is within or adjacent to a large public hospital as defined in 89 Ill. Adm. Code 148.25(a)(1).

2) County ambulatory health centers. A county ambulatory health center is a County-operated outpatient facility that is not a critical clinic provider.

3) County-operated outpatient facilities shall submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.462 Covered Services in Clinics

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

- a) Hospital-Based Organized Clinics

~~1) With respect to those hospital-based organized clinics that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e), as appropriate.~~

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~~12)~~ ~~With respect to all other hospital based organized clinics, Covered~~ covered services ~~are those~~ described in 89 Ill. Adm. Code 148.

~~23)~~ Group psychotherapy services ~~meeting must meet~~ the guidelines set forth in Section 140.413(a)(4)(C).

b) Encounter Rate Clinics

1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924~~(a)(2)(B)~~, covered services are those described in Section 140.922.

2) With respect to all other encounter rate clinics, covered services are medical services that provide for the continuous health care needs of persons who elect to use this type of service, including dental services that will be billed as separate encounters for dates of service on or after January 1, 2011.

3) Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

c) Rural Health Clinics

Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

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- B) laboratory services;
 - C) occupational therapy;
 - D) patient transportation;
 - E) pharmacy services;
 - F) physical therapy;
 - G) podiatric services;
 - H) speech and hearing services;
 - I) x-ray services;
 - J) health education;
 - K) nutrition services;
 - L) optometric services.
- 4) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.
 - 5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.
 - 6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services with the exception of services identified in subsections (c)(7) and (c)(8).
 - 7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an RHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

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- A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;
 - B) The RHC must be listed as the payee on the claim;
 - C) Reimbursement shall be made at the RHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;
 - D) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.
- 8) Effective July 1, 2013, an RHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:
- A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;
 - B) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;
 - C) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.
- d) Federally Qualified Health Centers
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:
- 1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).
 - 2) Other services for which separate encounters may be billed include dentists and behavioral health services as defined in Section 140.463(a).

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- 3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:
 - A) medical case management;
 - B) laboratory services;
 - C) occupational therapy;
 - D) patient transportation;
 - E) pharmacy services;
 - F) physical therapy;
 - G) podiatric services;
 - H) optometric services;
 - I) speech and hearing services;
 - J) x-ray services;
 - K) health education;
 - L) nutrition services.
- 4) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.
- 5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing.

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- 6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided with the exception of services identified in subsections (d)(7) and (d)(8).
- 7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an FQHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:
 - A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;
 - B) The FQHC must be listed as the payee on the claim;
 - C) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;
 - D) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.
- 8) Effective July 1, 2013, an FQHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:
 - A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;
 - B) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;
 - C) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

e) ~~Maternal and Child Health Clinics~~

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~~Payment shall be made to the Maternal and Child Health clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:~~

- ~~1) In the case of clinics described in Section 140.461(f)(1)(A) and (f)(1)(B), primary care services delivered by the clinic, which must include, but are not necessarily limited to:
 - ~~A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~
 - ~~B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;~~
 - ~~C) Regular immunizations for the prevention of childhood diseases;~~
 - ~~D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;~~
 - ~~E) Routine prenatal care, including risk assessment, for pregnant women; and~~
 - ~~F) Specialty care as medically needed.~~~~
- ~~2) In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic, which must include, but are not necessarily limited to:
 - ~~A) Prenatal care, including risk assessment (one risk assessment per pregnancy);~~
 - ~~B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and~~
 - ~~C) Services to pregnant women with diagnosed substance abuse or addiction problems.~~~~
- ~~3) In the case of clinics described in Section 140.461(f)(1)(D):~~

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- A) ~~Comprehensive medical and referral services.~~
- B) ~~Primary care services, which must include, but are not necessarily limited to:~~
 - i) ~~early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~
 - ii) ~~regular immunizations for the prevention of childhood diseases; and~~
 - iii) ~~follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.~~
- C) ~~Pediatric specialty services, which must include, at a minimum, necessary treatment for:~~
 - i) ~~asthma;~~
 - ii) ~~congenital heart disease;~~
 - iii) ~~diabetes, and~~
 - iv) ~~sickle cell anemia.~~
- D) ~~Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.~~

ef) School Based/Linked Health Clinics (Centers)

Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461 ~~(f)~~(e):

- 1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical

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Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.

- 2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.464 Hospital-Based and Encounter Rate Clinic Payments

- a) Hospital-Based Organized Clinics as described in Section 140.461(a) shall be paid in accordance with 89 Ill. Adm. Code 148.140

~~1) With respect to those hospital based organized clinics, as described at Section 140.461(a), that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), payment shall be in accordance with Section 140.930.~~

~~2) With respect to all other hospital based organized clinics, payment shall be in accordance with 89 Ill. Adm. Code 148.140.~~

- b) Encounter Rate Clinics

- 1) For encounter rate clinics, as described at Section 140.461(b), providing comprehensive health care for infants and women, including but not limited to prenatal and postnatal care, payment shall be made at the lesser of:

- A) \$90 per encounter; or
- B) The clinic's charge to the general public.

- 2) For encounter rate clinics, as described at Section 140.461(b), providing dental services, payment shall be made at the lesser of:

- A) \$85 per encounter; or

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- B) The clinic's historical annual cost per encounter as calculated for a Federally Qualified Health Center (FQHC) in accordance with Section 140.463(b)(3)(B).
- 3) For all other encounter rate clinics, payment shall be made at the lesser of:
 - A) The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or
 - B) \$50 per encounter; or
 - C) The clinic's charge to the general public.

c) County-operated outpatient facilities.

- 1) For critical clinic providers, as described in Section 140.461(h)(1), reimbursement for all services, including pharmacy-only-encounters, provided shall be on an all-inclusive per day encounter rate that shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.
- 2) For county ambulatory health centers, the final rate is determined as follows:
 - A) Base rate. The base rate shall be the rate calculated as follows:
 - i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.
 - ii) The resulting quotient, as calculated in subsection (i) of this subsection (c)(2)(A), shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

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iii) The resulting product, as calculated in subsection (ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (i) of this subsection (c)(2)(A), to determine the per encounter base rate.

iv) The resulting sum, as calculated in subsection (iii) of this Section, shall be the base rate.

B) Supplemental rate

i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.

ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.

iii) The quotient derived in subsection (i) of this subsection (c)(2)(B), shall be added to the product derived in subsection (ii) of this Section, to determine the per encounter supplemental rate.

iv) The resulting sum, as described in subsection (iii) of this subsection (c)(2)(B), shall be the supplemental rate.

C) Final rate. The final rate shall be the sum of the base rate and the supplemental rate.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section 140.930 Reimbursement

a) Reimbursement Rates for Maternal and Child Health Providers

1) ~~Participating providers described in Section 140.924(a)(1) will receive enhanced rates for certain medical services specified in Table M of this~~

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~~Part. The enhanced rates are effective for services provided on or after April 1, 1993.~~

- ~~12)~~ Participating FQHC's, as described in Section 140.461(d), that meet the criteria specified in 140.924(a)(2)(A), shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.
- ~~23)~~ Participating encounter rate clinics shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.
- ~~4)~~ ~~Participating Maternal and Child Health clinics, as described in Sections 140.924 and 140.461(f), will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.~~
- ~~35)~~ Participating providers described in Section 140.924(a)(1) shall be eligible to receive a Well Child Visit Incentive Payment.
 - A) The provider will receive a one-time annual payment of \$30 for each qualifying child.
 - B) A qualifying child is a child who had its first, second, third, fourth or fifth birthday during the calendar year and for whom the provider personally, or through an affiliated provider, rendered all recommended well child visits, as described in Section 140.488.
 - C) Recommended services must be rendered during the 13-month period ending one month after the child's birthday. For children turning one year old, the period begins ten days after birth and ends one month after the child's birthday. Rendering of services will be based on Department claims data.
 - D) ~~The first incentive payments shall be made by June 30, 2007 for children who met the definition of a qualifying child during calendar year 2005. Payments~~Subsequent payments will be made at least annually.

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- E) For the purpose of payments under this Section, "affiliated provider" shall mean providers designated pursuant to Section 140.994.
 - ~~i) For qualifying children during calendar year 2005 through 2007, a provider with the same payee in accordance with Section 140.24(d).~~
 - ~~ii) For qualifying children during calendar year 2008 and later, providers designated pursuant to Section 140.994.~~
- b) Patient Management Fee
Providers who have accepted primary care responsibilities for foster children residing in Cook County who are under the guardianship of the Department of Children and Family Services will receive a monthly patient management fee for each client enrolled with them.
- c) Case Management Services
Providers of case management services will receive monthly payments. The payments will be prorated based upon an annual amount per case.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART L: UNAUTHORIZED USE OF MEDICAL ASSISTANCE

Section 140. TABLE J Rate Regions HSA Grouping (Repealed)

These geographic regions, comprised of counties, are used in various rate methodologies and are defined as follows:

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Region 1–Northwestern.

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Illinois Counties:

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<u>Boone</u>	<u>Bureau</u>	<u>Carroll</u>	<u>DeKalb</u>	<u>Fulton</u>
<u>Henderson</u>	<u>Henry</u>	<u>JoDaviess</u>	<u>Knox</u>	<u>LaSalle</u>
<u>Lee</u>	<u>Marshall</u>	<u>Mercer</u>	<u>Ogle</u>	<u>Peoria</u>
<u>Putnam</u>	<u>Rock Island</u>	<u>Stark</u>	<u>Stephenson</u>	<u>Tazewell</u>
<u>Warren</u>	<u>Whiteside</u>	<u>Winnebago</u>	<u>Woodford</u>	

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Out of State Counties:

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Des Moines, IA Clinton, IA Dubuque, IA Johnson, IA Scott, IA
Dane, WI Green, WI Rock, WI Grant, WI LaFayette, WI
Jackson, IA Muscatine, IA Louisa, IA

Region 2–Central.

Illinois Counties:

<u>Adams</u>	<u>Brown</u>	<u>Calhoun</u>	<u>Cass</u>	<u>Champaign</u>
<u>Christian</u>	<u>Clark</u>	<u>Coles</u>	<u>Cumberland</u>	<u>DeWitt</u>
<u>Douglas</u>	<u>Edgar</u>	<u>Ford</u>	<u>Greene</u>	<u>Hancock</u>
<u>Iroquois</u>	<u>Jersey</u>	<u>Livingston</u>	<u>Logan</u>	<u>Macon</u>
<u>Macoupin</u>	<u>Mason</u>	<u>McDonough</u>	<u>McLean</u>	<u>Menard</u>
<u>Montgomery</u>	<u>Morgan</u>	<u>Moultrie</u>	<u>Piatt</u>	<u>Pike</u>
<u>Sangamon</u>	<u>Schuyler</u>	<u>Scott</u>	<u>Shelby</u>	<u>Vermilion</u>

Out of State Counties:

<u>Marion, IN</u>	<u>Vigo, IN</u>	<u>Marion, MO</u>	<u>Clark, MO</u>	<u>Lewis, MO</u>
<u>Ralls, MO</u>	<u>Pike, MO</u>	<u>Lincoln, MO</u>	<u>Newton, IN</u>	<u>Benton, IN</u>
<u>Warren, IN</u>	<u>Vermillion, IN</u>			

Region 3–Southern.

Illinois Counties:

<u>Alexander</u>	<u>Bond</u>	<u>Clay</u>	<u>Clinton</u>	<u>Crawford</u>
<u>Edwards</u>	<u>Effingham</u>	<u>Fayette</u>	<u>Franklin</u>	<u>Gallatin</u>
<u>Hamilton</u>	<u>Hardin</u>	<u>Jackson</u>	<u>Jasper</u>	<u>Jefferson</u>
<u>Johnson</u>	<u>Lawrence</u>	<u>Madison</u>	<u>Marion</u>	<u>Massac</u>
<u>Monroe</u>	<u>Perry</u>	<u>Pope</u>	<u>Pulaski</u>	<u>Randolph</u>
<u>Richland</u>	<u>Saint Clair</u>	<u>Saline</u>	<u>Union</u>	<u>Wabash</u>
<u>Washington</u>	<u>Wayne</u>	<u>White</u>	<u>Williamson</u>	

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Out of State Counties:

Vanderburgh, IN McCracken, KY Cape Girardeau, MO
St. Louis, MO City of St. Louis, MO St. Charles, MO Jefferson, MO
Gibson, IN Ste. Genevieve, MO Perry, MO Scott, MO
Mississippi, MO Posey, KY Livingston, KY Crittenden, KY
Union, KY Sullivan, IN Knox, IN

Region 4—Cook County.

Cook

Region 5—Collar Counties.

DuPage Grundy Kane Kankakee Kendall
Lake McHenry Will

Out of State Counties:

Milwaukee County, WI Walworth, WI Kenosha, WI Lake, IN

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992; added at 38 Ill. Reg. _____, effective _____)

Section 140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services
(Repealed)

a) ~~In accordance with Sections 140.464 and 140.930(a), certain providers who serve women will receive enhanced reimbursement rates for the following services:~~

CODE	DESCRIPTION
W7359	Prenatal risk assessment
59409	Vaginal delivery
59410	Vaginal delivery

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~~59500 C-section delivery~~

~~59514 C-section delivery~~

~~59515 C-section delivery~~

- b) ~~In accordance with Sections 140.464 and 140.930(a), certain providers who serve children under age 21 will receive enhanced reimbursement rates for the following services:~~

~~CODE DESCRIPTION~~

~~W7018 Healthy kids screening-Chicago-Downstate~~

~~W7360 Risk assessment, child referred for mental health assessment/services~~

~~W7361 Risk assessment, for mental health services, child, no referral~~

~~W7362 Risk assessment, for child referred for substance abuse assessment/treatment~~

~~W7363 Risk assessment for substance abuse, child, no referral~~

~~99201 Office visit—new patient—brief~~

~~99202 Office visit—new patient—limited~~

~~99203 Office visit—new patient—intermediate~~

~~99204 Office visit—new patient—extended~~

~~99205 Office visit—new patient—comprehensive~~

~~99211 Office visit—established patient—brief~~

~~99212 Office visit—established patient—limited~~

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99213 ~~Office visit—established patient—
intermediate~~

99214 ~~Office visit—established patient—extended~~

99215 ~~Office visit—established patient—
comprehensive~~

e) ~~All other visits and services billed under valid CPT-4 procedure codes will be
reimbursed at January 1, 1993, rates.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

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- 1) Heading of the Part: Specialized Health Care Delivery Systems
- 2) Code Citation: 89 Ill. Adm. Code 146
- 3)

<u>Section Number</u> :	<u>Proposed Action</u> :
146.100	Amendment
146.105	Amendment
146.110	Amendment
146.115	Amendment
146.125	Amendment
146.130	Amendment
146.840	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11.
- 5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? Yes

<u>Sections</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
146.840	Amendment	38 Ill. Reg. 18805; November 15, 2013
146.410	Amendment	38 Ill. Reg. 18951; December 2, 2013
146.440	Amendment	38 Ill. Reg. 18951; December 2, 2013

- 11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local

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government.

- 12) Time, Place, and Manner in which Interested Persons may Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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

217/782-1233

HFS.Rules@illinois.gov.

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
 - B) Reporting, bookkeeping or other procedures required for compliance: None
 - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this Rulemaking was Summarized: January 2014

The full text of the Proposed Amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 146

SPECIALIZED HEALTH CARE DELIVERY SYSTEMS

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

Section

146.100	General Description
146.105	Definitions
146.110	Participation Requirements
146.115	Records and Data Reporting Requirements
146.125	Covered Ambulatory Surgical Treatment Center Services
146.130	Reimbursement for Services

SUBPART B: SUPPORTIVE LIVING FACILITIES

Section

146.200	General Description
146.205	Definitions
146.210	Structural Requirements
146.215	SLF Participation Requirements
146.220	Resident Participation Requirements
146.225	Reimbursement for Medicaid Residents
146.230	Services
146.235	Staffing
146.240	Resident Contract
146.245	Assessment and Service Plan and Quarterly Evaluation
146.250	Resident Rights
146.255	Discharge
146.260	Grievance Procedure
146.265	Records and Reporting Requirements
146.270	Quality Assurance Plan
146.275	Monitoring
146.280	Non-Compliance Action
146.285	Voluntary Surrender of Certification
146.290	Geographic Groups

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- 146.295 Emergency Contingency Plan
- 146.300 Waivers
- 146.305 Reporting of Suspected Abuse, Neglect and Financial Exploitation
- 146.310 Facility Management of Resident Funds

SUBPART C: STATE HEMOPHILIA PROGRAM

Section

- 146.400 Definitions
- 146.410 Patient Eligibility
- 146.420 Hemophilia Treatment Centers
- 146.430 Comprehensive Care Evaluation
- 146.440 Home Transfusion Arrangements
- 146.450 Obligations of the Department

SUBPART D: CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTERS

Section

- 146.500 General Description
- 146.510 Definitions
- 146.520 Participation Requirements
- 146.530 Records and Data Reporting Requirements
- 146.540 Covered Children's Community-Based Health Care Center Services
- 146.550 Reimbursement for Services
- 146.560 Individuals Eligible for Services Provided in a Children's Community-Based Health Care Center
- 146.570 Prior and Post Approval of Services

SUBPART E: SUPPORTIVE LIVING FACILITIES WITH DEMENTIA CARE UNITS

Section

- 146.600 General Description
- 146.610 Structural Requirements
- 146.620 Participation Requirements
- 146.630 Resident Participation Requirements
- 146.640 Services
- 146.650 Reimbursement for Medicaid Residents
- 146.660 Staffing
- 146.670 Assessment and Service Plan and Quarterly Evaluation

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146.680 Monitoring
140.690 Reporting Requirements
146.700 Resident Rights
146.710 Discharge

SUBPART F: BIRTH CENTERS

146.800 General Description
146.810 Participation Requirements
146.820 Record Requirements
146.830 Covered Birth Center Services
146.840 Reimbursement of Birth Center Services

SOURCE: Old Part repealed at 14 Ill. Reg. 13800, effective August 15, 1990; new Part adopted at 20 Ill. Reg. 4419, effective February 29, 1996; emergency amendment at 21 Ill. Reg. 13875, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 4430, effective February 27, 1998; emergency amendment at 22 Ill. Reg. 13146, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19914, effective October 30, 1998; amended at 23 Ill. Reg. 5819, effective April 30, 1999; emergency amendment at 23 Ill. Reg. 8256, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13663, effective November 1, 1999; amended at 24 Ill. Reg. 8353, effective June 1, 2000; emergency amendment at 26 Ill. Reg. 14882, effective October 1, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 2176, effective February 1, 2003; emergency amendment at 27 Ill. Reg. 10854, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18671, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 12218, effective August 11, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 14214, effective October 18, 2004, for a maximum of 150 days; amended at 29 Ill. Reg. 852, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2014, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 4360, effective March 7, 2005; expedited correction at 29 Ill. Reg. 14127, effective March 7, 2005; amended at 29 Ill. Reg. 6967, effective May 1, 2005; amended at 29 Ill. Reg. 14987, effective September 30, 2005; amended at 30 Ill. Reg. 8845, effective May 1, 2006; amended at 31 Ill. Reg. 5589, effective April 1, 2007; emergency amendment at 31 Ill. Reg. 5876, effective April 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11681, effective August 1, 2007; amended at 33 Ill. Reg. 11803, effective August 1, 2009; emergency amendment at 36 Ill. Reg. 6751, effective April 13, 2012, for a maximum of 150 days; amended at 36 Ill. Reg. 13885, effective August 27, 2012; amended at 37 Ill. Reg. 17624, effective October 28, 2013; expedited correction at 38 Ill. Reg. _____, effective October 28, 2013; amended at 38 Ill. Reg. _____, effective _____.

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NOTICE OF PROPOSED AMENDMENTS

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

Section 146.100 General Description

This Part sets forth the conditions that an ambulatory surgical treatment center must meet in order to participate in the ~~Medical Assistance~~ ~~Medicaid~~ Program.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.105 Definitions

For purposes of this Part, the following terms shall be defined as follows:

- a) "Ambulatory Surgical Treatment Center (ASTC)." Any distinct entity that operates primarily for the purpose of providing surgical services to patients not requiring hospitalization. Such facilities shall not provide beds or other accommodations for the overnight stay of patients; however, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients for up to 23 hours following admission. Individual patients shall be discharged in an ambulatory condition without danger to the continued well-being of the patients or shall be transferred to a hospital or other similar environment. This provision shall include any place which meets the definition of an ambulatory surgical treatment center under the regulations of the ~~Centers for Medicare and Medicaid Services~~ ~~Federal Health Care Financing Administration~~ (42 CFR 416). The term "ambulatory surgical treatment center" does not include:
 - 1) Any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85].;
 - 2) Any person or institution required to be licensed pursuant to the Nursing Home Care Act [210 ILCS 45], ~~the ID/DD Community Care Act [210 ILCS 47], or the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49].;~~
 - 3) Hospitals or ambulatory surgical treatment centers maintained by the State or any department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control;

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- 4) Hospitals or ambulatory surgical treatment centers maintained by the federal government or agencies thereof.~~;~~ ~~or~~
- 5) Any place, agency, clinic or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures.
- b) "Ambulatory Surgical Treatment Center Services." Facility services that are furnished in an ambulatory surgical treatment center.
- c) "Department." The Illinois Department of ~~Public Health~~ Healthcare and Family Services.~~Public Aid.~~
- d) "Facility Services." Services that are furnished in connection with covered surgical procedures performed in an ambulatory surgical treatment center.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.110 Participation Requirements

To participate in the ~~Medical Assistance~~ Medicaid Program, an ambulatory surgical treatment center (ASTC) must, in addition to any other Department requirements:

- a) Be licensed by the Illinois Department of Public Health pursuant to 77 Ill. Adm. Code 205.
- b) In the case of an out-of-state ASTC, be licensed by ~~the~~~~their~~ state in which it is located ~~agency~~ or, where a state does not license ASTCs, be accredited by a national accrediting body.
- c) Meet the requirements in 42 CFR 416.
- d) Maintain a contractual relationship, including a transfer and referral plan with a hospital. Such a plan shall include procedures for effecting transfer of the patient from the ASTC to a hospital.
 - 1) The contracting hospital must be within 15 minutes of the ASTC.

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- 2) Have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the ASTC.
- e) Ensure that a qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients.
- f) Must perform surgical procedures in a safe manner using qualified physicians or dentists who have been granted clinical privileges by the governing body of the ASTC. These providers must be licensed in the State of Illinois or, for an out-of-state ASTC, licensed by the state in which they practice and have skilled equivalent practice privileges at a licensed hospital.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.115 Records and Data Reporting Requirements

- a) In addition to any other Department record requirements, the ambulatory surgical treatment center (ASTC) must maintain complete, comprehensive and accurate medical records to ensure adequate patient care that includes, but is not limited to, the following:
 - 1) Patient identification.‡
 - 2) Significant medical history and results of physical examination.‡
 - 3) Preoperative diagnostic studies (entered before surgery), if performed.‡
 - 4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body of the ASTC or State state law.‡
 - 5) Any known allergies and abnormal drug reactions.‡
 - 6) Entries related to anesthesia administration.‡
 - 7) Documentation of properly executed informed patient consent.‡
 - 8) Discharge diagnosis.‡ ~~and~~

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- 9) Medications ordered and administered.
- b) ASTC medical records must contain the dates of service and the name of the medical practitioner seeing the patient at the time of each center visit.
- c) Medical records for ~~Medical Assistance Medicaid~~ patients must be made available to the Department or its designated representative in the performance of utilization review.
- d) The ASTC agrees to furnish to the Department, if requested, information necessary to establish payment rates in the form and manner that the Department requires.
- e) Services provided in an ASTC may be subject to prepayment and post-payment review to assess medical care, coding validation and quality of care.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.125 Covered Ambulatory Surgical Treatment Center Services

Effective for dates of service on or after July 1, 2014:

- a) The Department of Healthcare and Family Services will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered ~~enhanced ambulatory patient group (EAPG) services as defined in 89 Ill. Adm. Code 148.140(b)(1). Ambulatory Procedure Listing (APL) Groupings, as defined in 89 Ill. Adm. Code 148.140(b)(1).~~ The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting.
- b) Facility services furnished by an ASTC in connection with covered APL codes include, but are not limited to:
 - 1) Nursing, technician and related services.;
 - 2) Use of the ASTC facilities.;

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- 3) Supplies (such as drugs, ~~biological products [e.g., blood]~~~~biologicals (for example, blood)~~), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of surgical procedures.;
 - 4) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.;
 - 5) Administrative, record keeping, and housekeeping items and services.;
 - 6) Materials for anesthesia.
- c) Facility services do not include items and services for which payment may be made under other provisions of this Section such as physicians' or dentists' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.130 Reimbursement for Services

Effective for dates of service on or after July 1, 2014:

- a) With respect to all ~~non-EAPG non-APL~~ procedures, reimbursement levels shall be at the lower of the ASTC's usual and customary charge to the public or the Department's Statewide maximum reimbursement screen.
- b) With respect to ~~EAPG-APL~~ procedures described in 89 Ill. Adm. Code 148.140(b)(1), reimbursement for such services shall be in accordance with an all-inclusive rate for facility services, and shall be calculated at 75 percent of the applicable group rate paid for that same procedure in a hospital outpatient setting, as described under 89 Ill. Adm. Code 148.140(d)(7)(b).
- c) Laboratory, x-ray, prescription, physicians' or ~~dental dentists'~~ services, provided in connection with a covered surgical procedure, must be billed by the providers rendering such services. If the ASTC provides the ~~laboratory lab~~ or x-ray service, then:

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- 1) Separate billing is NOT allowed if provided on the day of surgery; or
 - 2) Separate billing IS allowed if provided on other than the day of surgery.
- d) The providers described in subsection (c) of this Section must meet all applicable license, enrollment and reimbursement conditions of the Department of Healthcare and Family Services, the Department of Public Health and the Department of Financial and Professional Regulation-Division of Professional Regulation.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART F: BIRTH CENTERS

Section 146.840 Reimbursement of Birth Center Services

- a) Facility services provided by a birth center located in Cook County will be reimbursed at the lower of billed charges or 75 percent of the statewide average facility payment rate made to a hospital located in Cook County for an uncomplicated vaginal birth.
- b) Facility services provided by a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 75 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.
- c) Observation services will be reimbursed at the lower of billed charges or at 75 percent of the rate established by the Department for the number of hours of observation billed pursuant to 89 Ill. Adm. Code 148.140(b)(1)(D) as reflected in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, through dates of service on June 30, 2014. Effective for dates of service on or after July 1, 2014, observation services will be reimbursed at the lower of billed charges or \$53.56 for 1 hour through 6 hours, 30 minutes or more.
- d) Transfer fees for a birth center located in Cook County will be reimbursed at the lower of billed charges or 15 percent of the statewide average facility payment rate made to a hospital located in Cook County for an uncomplicated vaginal birth.

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- e) Transfer fees for a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 15 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.

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(Source: Amended at 38 Ill. Reg. ____, effective _____)

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NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

<u>Section Numbers:</u>	<u>Proposed Action:</u>
148.20	Amendment
148.25	Amendment
148.30	Amendment
148.40	Amendment
148.50	Amendment
148.60	Amendment
148.70	Amendment
148.82	Amendment
148.85	Repeal
148.90	Repeal
148.95	Repeal
148.100	Amendment
148.103	Repeal
148.105	Amendment
148.110	Amendment
148.112	Amendment
148.115	Amendment
148.116	New
148.117	Amendment
148.120	Amendment
148.122	Amendment
148.126	Amendment
148.140	Amendment
148.150	Amendment
148.160	Amendment
148.170	Amendment
148.175	Repeal
148.180	Amendment
148.200	Repeal
148.210	Amendment
148.220	Repeal
148.230	Repeal
148.240	Amendment
148.250	Repeal
148.260	Repeal
148.270	Repeal
148.280	Repeal

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148.290	Amendment
148.295	Amendment
148.296	Amendment
148.297	Amendment
148.298	Repeal
148.300	Amendment
148.310	Amendment
148.320	Repeal
148.330	Amendment
148.370	Amendment
148.390	Amendment
148.400	Amendment
148.440	Amendment
148.442	Amendment
148.444	Amendment
148.446	Amendment
148.448	Amendment
148.450	Amendment
148.452	Amendment
148.454	Amendment
148.456	Amendment
148.458	Amendment
148.460	Repeal
148.462	Repeal
148.464	Amendment
148.466	Amendment
148.468	Amendment
148.470	Amendment
148.472	Amendment
148.474	Amendment
148.476	Amendment
148.478	Amendment
148.480	Amendment
148.482	Amendment
148.484	Amendment
148.486	Amendment
148.860	Amendment
148.TABLE C	Amendment

- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11].

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- 5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? Yes

<u>Section</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
148.436	New	37 Ill. Reg. 18011; November 15, 2013
148.600	Amendment	37 Ill. Reg. 18959; December 2, 2013
148.610	Amendment	37 Ill. Reg. 18959; December 2, 2013
148.630	Amendment	37 Ill. Reg. 18959; December 2, 2013

- 11) Statement of Statewide Policy Objectives: This rulemaking does affect units of local government. It will have an impact on government-owned or government-operated hospitals.
- 12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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

217/782-1233

HFS.Rules@illinois.gov

The Department requests the submission of written comments within 45 days after the

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publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
 - B) Reporting, bookkeeping or other procedures required for compliance: None
 - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this Rulemaking was Summarized: January 2014

The full text of the Proposed Amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 148

HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS

Section

- 148.10 Hospital Services
- 148.20 Participation
- 148.25 Definitions and Applicability
- 148.30 General Requirements
- 148.40 Special Requirements
- 148.50 Covered Hospital Services
- 148.60 Services Not Covered as Hospital Services
- 148.70 Limitation On Hospital Services

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section

- 148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
- 148.82 Organ Transplant Services
- 148.85 Supplemental Tertiary Care Adjustment Payments ~~(Repealed)~~
- 148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments ~~(Repealed)~~
- 148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments ~~(Repealed)~~
- 148.100 ~~County Trauma Center Outpatient Rural Hospital~~ Adjustment Payments
- 148.103 Outpatient Service Adjustment Payments ~~(Repealed)~~
- 148.105 ~~Reimbursement Methodologies for Inpatient Rehabilitation Services~~ ~~Psychiatric~~
~~Adjustment Payments~~
- 148.110 ~~Reimbursement Methodologies for Inpatient~~ Psychiatric ~~Services~~ ~~Base Rate~~
~~Adjustment Payments~~
- 148.112 ~~Medicaid~~ High Volume Adjustment Payments
- 148.115 ~~Reimbursement Methodologies for Long Term Acute Care Services~~ ~~Rural~~
~~Adjustment Payments~~
- 148.116 Reimbursement Methodologies for Children's Specialty Hospitals
- 148.117 Outpatient Assistance Adjustment Payments
- 148.120 Disproportionate Share Hospital (DSH) Adjustments
- 148.122 Medicaid Percentage Adjustments
- 148.126 Safety Net Adjustment Payments
- 148.130 Outlier Adjustments for Exceptionally Costly Stays

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- 148.140 Hospital Outpatient and Clinic Services
- 148.150 Public Law 103-66 Requirements
- 148.160 Payment Methodology for County-Owned ~~Large Public Hospitals in an Illinois County with a Population of Over Three Million~~
- 148.170 Payment Methodology for ~~University-Owned Large Hospitals Organized Under the University of Illinois Hospital Act~~
- 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act ~~(Repealed)~~
- 148.180 Payment for Pre-operative Days ~~and Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting~~
- 148.190 Copayments
- 148.200 Alternate Reimbursement Systems ~~(Repealed)~~
- 148.210 Filing Cost Reports
- 148.220 Pre September 1, 1991, Admissions ~~(Repealed)~~
- 148.230 Admissions Occurring on or after September 1, 1991 ~~(Repealed)~~
- 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
- 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals ~~(Repealed)~~
- 148.260 Calculation and Definitions of Inpatient Per Diem Rates ~~(Repealed)~~
- 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals ~~(Repealed)~~
- 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements ~~(Repealed)~~
- 148.285 Excellence in Academic Medicine Payments (Repealed)
- 148.290 Adjustments and Reductions to Total Payments
- 148.295 Critical Hospital Adjustment Payments ~~(CHAP)~~
- 148.296 ~~Transitional Supplemental Tertiary Care Adjustment~~ Payments
- 148.297 ~~Physician Development Incentive Payments; Pediatric Outpatient Adjustment~~ Payments
- 148.298 Pediatric Inpatient Adjustment Payments ~~(Repealed)~~
- 148.300 Payment
- 148.310 Review Procedure
- 148.320 Alternatives ~~(Repealed)~~
- 148.330 Exemptions
- 148.340 Subacute Alcoholism and Substance Abuse Treatment Services
- 148.350 Definitions (Repealed)
- 148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.368 Volume Adjustment (Repealed)
- 148.370 Payment for Sub-acute Alcoholism and Substance Abuse Treatment Services

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- 148.380 Rate Appeals for Sub_acute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.390 Hearings
- 148.400 Special Hospital Reporting Requirements
- 148.402 Medicaid Eligibility Payments (Repealed)
- 148.404 Medicaid High Volume Adjustment Payments (Repealed)
- 148.406 Intensive Care Adjustment Payments (Repealed)
- 148.408 Trauma Center Adjustment Payments (Repealed)
- 148.410 Psychiatric Rate Adjustment Payments (Repealed)
- 148.412 Rehabilitation Adjustment Payments (Repealed)
- 148.414 Supplemental Tertiary Care Adjustment Payments (Repealed)
- 148.416 Crossover Percentage Adjustment Payments (Repealed)
- 148.418 Long Term Acute Care Hospital Adjustment Payments (Repealed)
- 148.420 Obstetrical Care Adjustment Payments (Repealed)
- 148.422 Outpatient Access Payments (Repealed)
- 148.424 Outpatient Utilization Payments (Repealed)
- 148.426 Outpatient Complexity of Care Adjustment Payments (Repealed)
- 148.428 Rehabilitation Hospital Adjustment Payments (Repealed)
- 148.430 Perinatal Outpatient Adjustment Payments (Repealed)
- 148.432 Supplemental Psychiatric Adjustment Payments (Repealed)
- 148.434 Outpatient Community Access Adjustment Payments (Repealed)
- 148.440 High Volume Adjustment Payments
- 148.442 Inpatient Services Adjustment Payments
- 148.444 Capital Needs Payments
- 148.446 Obstetrical Care Payments
- 148.448 Trauma Care Payments
- 148.450 Supplemental Tertiary Care Payments
- 148.452 Crossover Care Payments
- 148.454 Magnet Hospital Payments
- 148.456 Ambulatory Procedure Listing Increase Payments
- 148.458 General Provisions
- 148.460 Catastrophic Relief Payments (Repealed)
- 148.462 Hospital Medicaid Stimulus Payments (Repealed)
- 148.464 General Provisions
- 148.466 Magnet and Perinatal Hospital Adjustment Payments
- 148.468 Trauma Level II Hospital Adjustment Payments
- 148.470 Dual Eligible Hospital Adjustment Payments
- 148.472 Medicaid Volume Hospital Adjustment Payments
- 148.474 Outpatient Service Adjustment Payments
- 148.476 Ambulatory Service Adjustment Payments
- 148.478 Specialty Hospital Adjustment Payments
- 148.480 ER Safety Net Payments

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- 148.482 Physician Supplemental Adjustment Payments
- 148.484 Freestanding Children's Hospital Adjustment Payments
- 148.486 Freestanding Children's Hospital Outpatient Adjustment Payments

SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

Section

- 148.500 Definitions
- 148.510 Reimbursement

SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section

- 148.600 Definitions
- 148.610 Scope of the Program
- 148.620 Assistance Level and Reimbursement
- 148.630 Criteria and Information Required to Establish Eligibility
- 148.640 Covered Services

SUBPART E: INSTITUTION FOR MENTAL DISEASES PROVISIONS FOR HOSPITALS

Section

- 148.700 General Provisions

SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

Section

- 148.800 General Provisions
- 148.810 Definitions
- 148.820 Individual Eligibility for the Program
- 148.830 Providers Participating in the Program
- 148.840 Stabilization and Discharge Practices
- 148.850 Medication Management
- 148.860 Community Connect IMD Hospital Payment
- 148.870 Community Connect TCM Agency Payment
- 148.880 Program Reporting

- 148.TABLE A Renal Participation Fee Worksheet
- 148.TABLE B Bureau of Labor Statistics Equivalence
- 148.TABLE C List of Metropolitan Counties by SMSA Definition

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of

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the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January

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26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of

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150 days; emergency expired June 7, 2004; amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7101, effective May 3, 2004; amended at 28 Ill. Reg. 8072, effective June 1, 2004; emergency amendment at 28 Ill. Reg. 8167, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9661, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10157, effective July 1, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12036, effective August 3, 2004, for a maximum of 150 days; emergency expired December 30, 2004; emergency amendment at 28 Ill. Reg. 12227, effective August 6, 2004, for a maximum of 150 days; emergency expired January 2, 2005; amended at 28 Ill. Reg. 14557, effective October 27, 2004; amended at 28 Ill. Reg. 15536, effective November 24, 2004; amended at 29 Ill. Reg. 861, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2026, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; amended at 30 Ill. Reg. 383, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 955, effective January 9, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 2827, effective February 24, 2006; emergency amendment at 30 Ill. Reg. 7786, effective April 10, 2006, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 12400, effective July 1, 2006, for the remainder of the 150 days; emergency expired September 6, 2006; amended at 30 Ill. Reg. 8877, effective May 1, 2006; amended at 30 Ill. Reg. 10393, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18672, effective November 27, 2006; emergency amendment at 31 Ill. Reg. 1602, effective January 1, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 1997, effective January 15, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 5596, effective April 1, 2007; amended at 31 Ill. Reg. 8123, effective May 30, 2007; amended at 31 Ill. Reg. 8508, effective June 1, 2007; emergency amendment at 31 Ill. Reg. 10137, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11688, effective August 1, 2007; amended at 31 Ill. Reg. 14792, effective October 22, 2007; amended at 32 Ill. Reg. 312, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 518, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 2993, effective February 16, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8718, effective May 29, 2008; amended at 32 Ill. Reg. 9945, effective June 26, 2008; emergency amendment at 32 Ill. Reg. 10517, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 33 Ill. Reg. 501, effective December 30, 2008; preemptory amendment at 33 Ill. Reg. 1538, effective December 30, 2008; emergency amendment at 33 Ill. Reg. 5821, effective April 1, 2009, for a

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maximum of 150 days; emergency expired August 28, 2009; amended at 33 Ill. Reg. 13246, effective September 8, 2009; emergency amendment at 34 Ill. Reg. 15856, effective October 1, 2010, for a maximum of 150 days; emergency expired February 27, 2011; amended at 34 Ill. Reg. 17737, effective November 8, 2010; amended at 35 Ill. Reg. 420, effective December 27, 2010; amended at 35 Ill. Reg. 10033, effective June 15, 2011; amended at 35 Ill. Reg. 16572, effective October 1, 2011; emergency amendment at 36 Ill. Reg. 10326, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 148.70(g) suspended at 36 Ill. Reg. 13737, effective August 15, 2012; suspension withdrawn from Section 148.70(g) at 36 Ill. Reg. 18989, December 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 148.70(g) at 36 Ill. Reg. 18976, effective December 12, 2012 through June 30, 2013; emergency amendment to Section 148.140(b)(1)(F) suspended at 36 Ill. Reg. 13739, effective August 15, 2012; suspension withdrawn from Section 148.140(b)(1)(F) at 36 Ill. Reg. 14530, September 11, 2012; emergency amendment to Sections 148.140(b) and 148.190(a)(2) in response to Joint Committee on Administrative Rules action at 36 Ill. Reg. 14851, effective September 21, 2012 through June 30, 2013; amended at 37 Ill. Reg. 402, effective December 27, 2012; emergency rulemaking at 37 Ill. Reg. 5082, effective April 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10432, effective June 27, 2013; amended at 37 Ill. Reg. 17631, effective October 23, 2013; amended at 38 Ill. Reg. _____, effective January 19, 2014; amended at 38 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

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Section 148.20 Participation

Effective for dates of service on or after July 1, 2014:

- a) Payment for hospital inpatient, outpatient and clinic services shall be made only when provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), for covered services, as described in Section 148.50.
- b) ~~Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992 through March 31, 1994 shall be as follows:~~
 - 1) ~~Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated~~

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~~effective October 1, 1992, under the following Sections: 148.130, 148.260, 148.270, and 148.280.~~

- 2) ~~Exemptions. The provisions of subsection (b)(1) shall not apply to:~~
- A) ~~Hospitals reimbursed under Sections 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with Sections 148.82, 148.160, or 148.170, as applicable.~~
 - B) ~~Hospitals reclassified as rural hospitals as described in Section 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with Section 148.40(f)(4) and Section 148.260 or 89 Ill. Adm. Code 149.100(e)(1)(A), whichever is applicable.~~
 - C) ~~The inpatient payment adjustments described in Sections 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with Sections 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1).~~
- b) Payment for freestanding emergency center services shall only be made when provided by a freestanding emergency center as defined in Section ~~148.25(e)~~148.25(h) of this Part.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.25 Definitions and Applicability

Effective for dates of service on or after July 1, 2014:

- a) The term "large public hospital" means a hospital:
- 1) Owned by and located in an Illinois county with a population exceeding three million, or
 - 2) Organized under the University of Illinois Hospital Act, or
 - 3) Maintained by the Illinois Department of Human Services.

~~Payment for hospital inpatient, hospital outpatient and hospital clinic services shall be made only to a hospital or a distinct part hospital unit as defined in this Section.~~

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b) The term "hospital" means:

1) For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which:

A) Is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act.

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B) Is organized under the University of Illinois Hospital Act.

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C) Is maintained by the State, or any department or agency thereof, where such department or agency has authority under the law to establish and enforce standards for the hospitalization or care facilities under its management and control.

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D) Which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.

~~is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not for profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of inpatient reimbursement, the term "hospital" shall also include:~~

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~~A) County-owned hospitals, meaning all county-owned hospitals that are located in an Illinois county with a population of over 3 million.~~

~~B) A hospital organized under the University of Illinois Hospital Act.~~

~~C) A hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act or the University of Illinois Hospital Act.~~

2) For the purpose of hospital outpatient reimbursement, the term "hospital" shall, in addition to the definition described in subsection (b)(1) of this Section, include ~~an encounter rate hospital. An encounter rate hospital is defined as:~~

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- A) ~~An ambulatory surgical treatment facility, as described in 89 Ill. Adm. Code Part 146.105(a). An Illinois county-owned hospital located in a county with a population exceeding three million;~~
 - B) ~~A free-standing emergency center, as described in subsection (e) of this Section, hospital organized under the University of Illinois Hospital Act; or~~
 - C) ~~A county-operated outpatient facility located in a county with a population exceeding three million that is also located in the State of Illinois.~~
- 3) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean a county-operated outpatient facility owned by and located in an Illinois county with a population exceeding three million.
- A) ~~A county-operated outpatient facility, as described in subsection (b)(2)(D) of this Section; or~~
 - B) ~~A Certified Hospital Organized Satellite Clinic, as described in 89 Ill. Adm. Code 140.461(f)(1)(B).~~
- 4) For the purpose of hospital-based clinic reimbursement, the term "hospital" shall mean a hospital-based clinic meeting the provisions of Section 148.40(d) and 89 Ill. Adm. Code 140.461(a) ~~and Section 148.40(d).~~
- 5) ~~For the purpose of Maternal and Child Health reimbursement, as described in 89 Ill. Adm. Code 140.464 and Section 148.140(d)(6), the term "Maternal and Child Health Managed Care Clinic" shall mean a clinic meeting the requirements of 89 Ill. Adm. Code 140.461(f). The following four categories of Maternal and Child Health Managed Care Clinics are recognized under the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140, Subpart G:~~
- A) ~~Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A);~~
 - B) ~~Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B);~~

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- ~~C) Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C); and~~
- ~~D) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D).~~
- ~~6) For the purpose of disproportionate share hospital adjustments, the term "hospital" shall, in addition to the definition in subsection (b)(1) of this Section, mean the facilities operated by the Department of Human Services, including facilities that are accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO).~~
- c) For the purpose of hospital inpatient reimbursement, the term "distinct part ~~hospital~~ unit" means a unit within a hospital, as defined in subsection (b)(1) of this Section; that meets the following qualifications:
 - 1) Distinct Part Psychiatric Units. A distinct part psychiatric unit is a ~~hospital, with a~~ functional ~~psychiatric~~ unit, that is enrolled with the Department to provide inpatient psychiatric services (category of service 021).
 - 2) Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a ~~hospital, with a~~ functional ~~rehabilitation~~ unit, that is enrolled with the Department to provide inpatient rehabilitation services (category of service 022).
- d) ~~Specialty Hospitals. A major teaching hospital is defined as a hospital having four or more graduate medical education programs accredited by 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. Except, in the case of a hospital devoted exclusively to physical rehabilitation, as defined in 89 Ill. Adm. Code 149.50(e)(2), or in the case of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(e)(3), only one certified program is required to be so classified.~~
 - 1) Psychiatric Hospitals. To qualify as a psychiatric hospital, a facility must be:
 - A) Licensed by the state within which it is located as a psychiatric hospital and be primarily engaged in providing, by or under the

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supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons.

B) Enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 021).

2) Rehabilitation Hospitals. To qualify as a rehabilitation hospital, a facility must be:

A) Licensed by the state within which it is located as a physical rehabilitation hospital.

B) Enrolled with the Department as a rehabilitation hospital to provide inpatient physical rehabilitation services (category of service 022).

3) Children's Hospitals. To qualify as a children's hospital, a facility must be devoted exclusively to caring for children and either be:

A) A hospital licensed by the state within which it is located as a pediatric, psychiatric, or children's hospital.

B) A unit within a general hospital that was enrolled with the Department as a children's hospital on July 1, 2013. Units so enrolled shall be reimbursed for all inpatient and outpatient services provided to Medical Assistance enrollees who are under 18 years of age, with the exception of obstetric services, normal newborn nursery services, psychiatric services, and physical rehabilitation services, without regard to the physical location within the hospital where the care is rendered.

4) Long Term Acute Care Hospitals. To qualify as a long term acute care hospital, a facility must be licensed by the state within which it is located as an acute care hospital and certified by Medicare as a long term care hospital.

e) The term "freestanding emergency center" means a facility that provides comprehensive emergency treatment services 24-hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Freestanding Emergency Center Code (77 Ill. Adm. Code 518), as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] in effect for the jurisdiction in which

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~~it is located. Except as provided in subsection (d) of this Section, a teaching hospital is defined as a hospital having at least one, but no more than three, graduate medical education programs accredited by 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.~~

f) ~~The term "coordinated care participating hospital" means a hospital, located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 ILCS 5/5-30 that: A non-teaching hospital is defined as:~~

- 1) ~~Has entered into a contract to provide hospital services to enrollees of the care coordination program. A hospital that reports teaching costs on the Medicare or Medicaid cost reports but has no graduate medical education programs; or~~
- 2) ~~Has not been offered a contract by a care coordination plan that pays not less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplement payment that the Department pays directly. A hospital that reports no teaching costs on the Medicare or Medicaid cost reports and that has no graduate medical education programs.~~

g) ~~The term "critical access hospital" means a hospital, located in Illinois that has been designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, Subpart F, Definitions. Unless specifically stated otherwise, the definitions of terms used in Sections 148.130, 148.260, 148.270, and 148.280, and in 89 Ill. Adm. Code 149 are as follows:~~

- 1) ~~"Base period" means the two most recent cost report years for which audited cost reports are available for at least 90 percent of cost reporting hospitals.~~
- 2) ~~"Rate period" means:~~
 - A) ~~For admissions, or if applicable, dates of service, on or after October 1, 1992, and on or before March 31, 1994, the 18 month period beginning on October 1, 1992, and ending on March 31, 1994.~~

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- ~~B) Beginning with admissions, or if applicable, dates of service, on or after April 1, 1994, the period beginning 90 days after the effective date of DRG PPS rates under the federal Medicare Program and ending 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.~~
- 3) "Rural hospital" means a hospital that is:
- A) Located:
- i) Outside a metropolitan statistical area; or
- ii) Located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health.
- B) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993).
- ~~4) "Urban hospital" means a hospital that is located in a metropolitan statistical area that does not meet the criteria described in subsection (g)(3) of this Section.~~
- h) Academic medical centers and major teaching hospital status. Hospitals dedicated to medical research and medical education shall be classified each State fiscal year in 3 tiers based on specific criteria:
- 1) Tier I. A private academic medical center must:
- A) be a hospital located in Illinois which is:
- i) under common ownership with the college of medicine of a non-public college or university; or
- ii) a freestanding hospital in which the majority of the clinical chiefs of service or clinical department chairs are

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department chairmen in an affiliated non-public Illinois medical school; or

iii) a children's hospital which is separately incorporated and non-integrated into the academic medical center hospital but is the pediatric partner for an academic medical center hospital and which serves as the primary teaching hospital for pediatrics for its affiliated Illinois medical school. A hospital identified herein is deemed to meet the additional Tier I criteria if its partner academic medical center hospital meets the Tier I criteria.

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B) serve as the training site for at least 30 graduate medical education programs accredited by Accreditation Council for Graduate Medical Education;

C) facilitate the training on the campus or on affiliated off-campus sites no less than 500 medical students, interns, residents, and fellows during the calendar year preceding the beginning of the State fiscal year;

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D) perform either itself or through its affiliated university, at least \$12,000,000 in medical research funded through grants or contracts from the National Institutes of Health or, with respect to hospitals described in subsection (h)(1)(A)(ii), have as its affiliated non-public Illinois medical school, a medical school that performs either itself, or through its affiliated University, medical research funded using at least \$12,000,000 in grants or contracts from the National Institutes of Health; and

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E) expend directly or indirectly through an affiliated non-public medical school or as part of a hospital system as defined as a hospital and one or more other hospitals or hospital affiliates related by common control or ownership, no less than \$5,000,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.

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2) Tier II. A public academic medical center must:

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A) be a hospital located in Illinois that is a primary teaching hospital affiliated with:

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- i) University of Illinois School of Medicine at Chicago; or
- ii) University of Illinois School of Medicine at Peoria; or
- iii) University of Illinois School of Medicine at Rockford; or
- iv) University of Illinois School of Medicine at Urbana; or
- v) Southern Illinois University School of Medicine in Springfield; and
- B) contribute no less than \$2,500,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.
- 3) Tier III. A major teaching hospital must:
 - A) be an Illinois hospital with 100 or more interns and residents or with a ratio of interns and residents to beds greater than or equal to 0.25; and
 - B) support at least one graduate medical education program accredited by Accreditation Council for Graduate Medical Education.

The term "freestanding emergency center" means a facility that provides comprehensive emergency treatment services 24 hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the EMS Systems Act in effect for the jurisdiction in which it is located.

- i) Children's specialty hospital. To qualify as a children's specialty hospital, a facility must be an Illinois hospital as defined in subsection (d)(3)(A) of this Section and have fewer than 50 total inpatient beds.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.30 General Requirements

Effective for dates of service on or after July 1, 2014:

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- a) For the purpose of hospital inpatient, hospital outpatient and hospital-based clinic reimbursement, the following requirements must be met by a hospital to qualify for enrollment in the Illinois Medical Assistance Program:
 - ~~b1)~~ The hospital must be certified for participation in the Medicare Program (Title XVIII) unless the provisions of subsection (c) ~~(a)(2)~~ of this Section apply.
 - ~~c2)~~ If not eligible for or subject to Medicare certification, the hospital must be accredited by ~~The the~~ Joint Commission (TJC) ~~on the Accreditation of Healthcare Organizations (JCAHO)~~.
 - ~~d3)~~ The hospital must agree to accept the Department's basis for reimbursement.
 - ~~b)~~ ~~Hospitals shall be required to file Medicaid and Medicare cost reports with the Office of Health Finance, Illinois Department of Public Aid, in accordance with Section 148.210, and shall have reimbursable hospital inpatient, outpatient and hospital-based clinic rates approved by the Department.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.40 Special Requirements

Effective for dates of service on or after July 1, 2014:

- a) Inpatient Psychiatric Services
 - 1) Payment for inpatient hospital psychiatric services shall be made only to:
 - A) A hospital that is a general hospital, as defined in Section 148.25(b), with a functional unit, as defined in Section 148.25(c)(1), that specializes in, and is enrolled with the Department to provide, psychiatric services; or
 - B) A hospital, as defined in Section 148.25(b), that holds a valid license as, and is enrolled with the Department as, a psychiatric hospital, as defined in Section 148.25(d)(1), ~~89 Ill. Adm. Code 149.50(e)(1)~~.
 - 2) Inpatient psychiatric services are those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder.

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- ~~3)~~ ~~Inpatient psychiatric services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.~~
- 34) Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his ~~or~~ her 21st birthday, reimbursement for psychiatric services ~~shall be reimbursable by the Department shall be provided~~ until the earliest of the following:
- A) The date the patient no longer requires the services, ~~or~~
 - B) The date the patient reaches 22 years of age.
- 45) A psychiatric hospital must be accredited by ~~The~~ the Joint Commission (TJC) ~~on the Accreditation of Health Care Organizations~~ to provide services to program participants under 21 years of age or be Medicare certified to provide services to program participants 65 years of age and older. Distinct part psychiatric units and psychiatric hospitals located in ~~the State of~~ Illinois, or within a ~~100 miles-mile radius of the State of~~ Illinois, must execute an ~~interagency~~ agreement with ~~an Illinois a~~ Department of Human Services (DHS) operated mental health center (State-operated facility) for coordination of services including, but not limited to, crisis screening and discharge planning to ensure linkage to aftercare services with private practitioners or community mental health services, as described in subsection (a) ~~(5)(6)~~ of this Section.
- 56) Coordination of Care – Purpose. ~~In accordance with subsection (a)(5) of this Section, distinct part psychiatric units and psychiatric hospitals located in the State of Illinois, or within a 100 mile radius of the State of Illinois, must execute a Coordination of Care Agreement in order to participate as a provider of inpatient psychiatric services.~~ The Coordination of Care Agreement shall set forth an agreement between the ~~DHS-operated mental health center (State-operated facility)~~ and the hospital for the coordination of services, including but not limited to crisis screening and discharge planning to ensure efficient use of inpatient care. The agreement shall also set forth the manner in which linkage to aftercare services with community mental health agencies or private practitioners shall be carried out.

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~~67~~) Coordination of Care – General Provisions. The general provisions of the Coordination of Care Agreement described in subsection (a) ~~(5)(6)~~ of this Section are as follows:

- A) The hospital shall agree, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations and shall maintain accreditation by ~~TJC/CAHO~~;
- B) The provider shall comply with Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 and regulations promulgated ~~there under thereunder~~ which prohibit discrimination on the grounds of sex, race, color, national origin or handicap;
- C) The provider shall comply with the following applicable federal, State and local statutes pertaining to equal employment opportunity, affirmative action, and other related requirements: 42 USCA 2000e, 29 USCA 203 et seq. and 775 ILCS 25;
- D) The Coordination of Care Agreement shall remain in effect until amended by mutual consent or cancelled in writing by either party having given 30 days prior notification.

~~78~~) Coordination of Care – Special Requirements. The hospital shall:

- A) Provide on its premises, the facilities, staff, and programs for the diagnosis, admission, and treatment of persons who may require inpatient care ~~and/or~~ assessment of mental status, mental illness, emotional disability, and other psychiatric problems;
- B) Notify the community mental health agency that serves the geographic area from which the recipient originated to allow the agency to prescreen the case prior to referring the individual to the designated State-operated facility. The community mental health agency's resources and other appropriate community alternatives shall be considered prior to making a referral to the State-operated facility for admission;
- C) Complete any forms necessary and consistent with the Mental Health and Developmental Disabilities Code in the event of a referral for involuntary or judicial admission;

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- D) Notify the community mental health agency or private practitioner of the date and time of discharge and invite their participation in the discharge planning process. ~~;~~
- E) Refer to the State-operated facility only those individuals for whom less restrictive alternatives are documented not to be appropriate at the time based on a clinical determination by the community mental health agency, a private practitioner (if applicable), or the hospital. ~~;~~ ~~and~~
- F) Notify the State-operated facility prior to planned transfer of an individual and transfer the individual at such time as to assure arrival of the person prior to 11 a.m. Monday through Friday. In unusual situations, transfers may be made at other times after prior discussion between the hospital and the State-operated facility. The individual will only be transported to the State-operated facility when, based on a clinical determination, he ~~or~~ she is medically stable as determined by the transferring physician. A copy of the transfer summary from the hospital must accompany the recipient at the time of admission to the State-operated facility.

89) Coordination of Care – Special Requirements of the State-Operated Facility. The State-operated facility shall:

- A) Admit individuals who have been screened as defined in the Coordination of Care Agreement and are appropriate for admission consistent with the provisions of the Mental Health and Developmental Disabilities Code.
- B) Evaluate individuals for whom the hospital has executed a Petition and Certificate for involuntary/judicial admission consistent with the Mental Health and Developmental Disabilities Code.
- C) Consider for admission voluntary individuals for whom less restrictive alternatives are documented not to be appropriate at the time, based on a clinical determination by the community mental health agency, private practitioner (if applicable), the hospital, or the State-operated facility.

94) Coordination of Care – Special Requirements for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program. For

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~~individuals~~patients under 21 years of age, all inpatient admissions must be authorized through the SASS Program. The hospital shall:

- A) Prior to admission, contact the Crisis and Referral Entry Service (CARES), the Department's Statewide centralized intake and referral point for a mental health screening and assessment of the patient, pursuant to 59 Ill. Adm. Code 131.40;
- B) For admissions authorized through a SASS screening, involve the SASS provider in the patient's treatment plan during the inpatient stay and in the development of a discharge plan in order to facilitate linkage to appropriate aftercare resources.

~~1044~~) A participating hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric services are secondary to the services for which the period of hospitalization is approved.

b) Inpatient Rehabilitation Services

- 1) Payment for inpatient rehabilitation services shall be made only to a general hospital, as defined in Section 148.25(b), with a functional unit of the hospital, as defined in Section 148.25(c)(2), which specializes in, and is enrolled with the Department to provide, physical rehabilitation services or a hospital, as defined in Section 148.25(d)(2) ~~89 Ill. Adm. Code 149.50(e)(2)~~, which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.
- 2) The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to the patient with a major handicap for the purpose of habilitating or restoring the person to a realistic maximum level of functioning.

~~3)~~ ~~Inpatient rehabilitation services are not covered for Temporary Assistance for Needy Families (TANF) program participants who are 18 years of age or older.~~

~~34)~~ For payment to be made, a rehabilitation facility, which includes a distinct part unit as described in Section 148.25(c)(2), must be certified ~~by the Health Care Financing Administration~~ for participation under the Medicare Program ~~(Title XVIII)~~ and must be licensed and/or certified by

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the Department of Public Health (DPH) to provide comprehensive physical rehabilitation services. Out-of-state hospitals that specialize in physical rehabilitation services must be licensed or certified to provide comprehensive physical rehabilitation services by the authorized licensing agency in the state in which the hospital is located.

- 45) A rehabilitation facility must meet the following criteria:
- A) Have a full-time (at least 35 hours per week) director of rehabilitation; a participating general hospital with a functional rehabilitation unit must have a part-time (at least 20 hours per week) director of rehabilitation.;
 - B) Have an organized medical staff.;
 - C) Have available consultants qualified to perform services in appropriate specialties.;
 - D) Have adequate space and equipment to provide comprehensive diagnostic and treatment services.;
 - E) Maintain records of diagnosis, treatment progress (notations must be made at regular intervals) and functional results.;
 - F) Submit reports as required by the Department ~~of Healthcare and Family Services (HFS).~~
- 56) A rehabilitation facility must provide, or have a contractual arrangement with an appropriate entity or agency to provide, the following minimal services:
- A) Full-time nursing services under the supervision of a registered nurse formally trained in rehabilitation nursing.;
 - B) Full-time physical therapy and occupational therapy services.;
 - C) Social casework services as an integral part of the rehabilitation program.
- 67) A rehabilitation facility must have available the following minimal services:

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- A) Psychological evaluation services~~;~~
- B) Prosthetic and orthotic services~~;~~
- C) Vocational counseling~~;~~
- D) Speech therapy~~;~~
- E) Clinical laboratory and x-ray services~~;~~~~and~~
- F) Pharmacy services.

78) The director of rehabilitation must meet the following criteria:

- A) Provide services to the hospital and its patients as specified in subsection (b)~~(4)(5)~~ of this Section~~;~~
- B) Be a doctor of medicine or osteopathy~~;~~
- C) Be licensed under State law to practice medicine or surgery~~;~~~~and~~
- D) Must have, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

89) Personnel of the rehabilitation facility must meet the following minimum standards:

- A) Physicians shall have unlimited licenses to practice medicine and surgery in the state in which they practice. Consultants shall be Board Qualified or Board Certified in their specialty.
- B) Physical therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.
- C) Occupational therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.
- D) Registered nurses and licensed practical nurses shall be currently licensed by the Illinois Department of Financial and Professional

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Regulation or comparable licensing agency in the ~~state~~State in which the facility is located.

- E) Social workers shall have completed two years of graduate training leading to a Master's Degree in social work from an accredited graduate school of social work.
 - F) Psychologists shall have a Master's Degree in clinical psychology.
 - G) Vocational counselors shall have a Master's Degree in Rehabilitation Counseling, Psychology or Guidance from a school accredited by the North Central Association or its equivalent.
 - H) An orthotist or prosthetist, certified by the American Board of Certification in Orthotics and Prosthetics, shall fabricate or supervise the fabrication of all limbs and braces.
- c) End-Stage Renal Disease Treatment (ESRDT) Services. The Department provides payment to hospitals, as defined in Section 148.25(b), for ESRDT services only when the hospital is Medicare certified for ESRDT and services are provided as follows:
- 1) Inpatient hospital care is provided for the evaluation and treatment of acute renal disease.
 - 2) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, or a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (~~2013+994~~).
 - 3) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, in a patient's home, or through a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (~~2013+994~~).
- d) Hospital-Based Organized Clinic Services. Hospital-based clinics, as described in Section 148.25(b)(4), must meet the requirements of 89 Ill. Adm. Code 140.461(a). The following two categories of hospital-based organized clinic services are recognized in the Medical Assistance Program:

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1) Psychiatric Clinic Services

- A) Psychiatric Clinic Services (Type A). Type A psychiatric clinic services are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting.
- B) Psychiatric Clinic Services (Type B). Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four hours per day at a minimum of three half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any 12 month period.
- ~~C) Coverage. Psychiatric clinic services are covered for all Medicaid-eligible individuals. The services are not covered for TANF participants who are 18 years of age or older.~~
- ~~CD) Approval. The Department and the Department of Human Services (DHS) ~~and HFS~~ are responsible for approval and enrollment of community hospitals providing psychiatric clinic services. In order to participate as a provider of psychiatric clinic services, a hospital must have previously been enrolled with the Department for the provision of inpatient psychiatric services on or after June 1, 2002 or must be currently enrolled for the provision of inpatient psychiatric services and execute a Psychiatric Clinic Services Type A and B Enrollment Assurance with DHS and the Department~~HFS~~, which assures that the hospital is enrolled for the provision of inpatient psychiatric services and meets the following requisites:
 - i) The hospital must be accredited by, and be in good standing with, ~~TJC, the Joint Commission on Accreditation of Health Care Organizations (JCAHO);~~
 - ii) The hospital must have executed a Coordination of Care Agreement between the hospital and the designated DHS State-operated facility serving the mentally ill in the appropriate geographic area.;~~

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iii) The clinical staff of the psychiatric clinic must collaborate with the mental health service network to provide discharge, linkage and aftercare planning for recipients of outpatient services.

~~iv) The hospital must agree to participate in Local Area Networks in compliance with P.L. 99-660 and P.A. 86-844; and~~

~~iv)~~ The hospital must be enrolled to participate in Medicaid Program (Title XIX) and must meet all conditions and requirements set forth by ~~the Department~~ HFS.

~~DE)~~ Duration of Approval. The approval described in subsection (d)(1)(D) of this Section shall be in effect for a period of two years from the date HFS approves the psychiatric clinic's enrollment. The approval may be terminated by HFS or DHS with cause upon 30 days written notice to the hospital. Accordingly, the hospital must submit a 30 day written notification to HFS and DHS when terminating delivery of psychiatric clinic services.

2) Physical Rehabilitation Clinic Services

~~A)~~ Physical rehabilitation clinic services include the same rehabilitative services provided to inpatients by hospitals enrolled to provide the services described in Section 148.40(b). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.

~~B)~~ ~~Physical rehabilitation clinic services are not covered for TANF participants who are 18 years of age or older.~~

~~e)~~ ~~Maternal and Child Health Clinics. Maternal and Child Health Clinics, as described in 89 Ill. Adm. Code 140.461(f) and Section 148.25(b)(5), must meet the requirements of 89 Ill. Adm. Code 140.461(f).~~

~~f)~~ ~~Transition to the Diagnosis-Related Grouping Prospective Payment System (DRG PPS) (see 89 Ill. Adm. Code 149)~~

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- 1) ~~Effective with admissions occurring on or after September 1, 1991, and before October 1, 1992, hospitals shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~
- 2) ~~Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act [20 ILCS 2215] and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care in accordance with subsection (g) of this Section.~~
- 3) ~~In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section 148.25(g)(2)(A):~~
 - A) ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, or~~
 - B) ~~the rate calculated under Section 148.260.~~
- 4) ~~In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in Section 148.25(g)(3), on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A):~~
 - A) ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(e)(1), or~~
 - B) ~~the rate calculated under Section 148.260 that would have been in effect for the rate period described in Section 148.25(g)(2)(A) if~~

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~~the hospital had been designated as a sole community hospital on October 1, 1992.~~

~~5) For the rate periods described in Section 148.25(g)(2)(B), hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided during such rate periods described in Section 148.25(g)(2)(B):~~

~~A) the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(e)(1), or~~

~~B) the rate calculated under Section 148.260.~~

~~g) Annual Irrevocable Election~~

~~1) Hospitals described in subsections (f)(2) and (f)(3) of this Section may elect to be reimbursed under the special arrangements described in subsections (f)(2) and (f)(3) at the beginning of each rate period.~~

~~2) Hospitals described in subsection (f)(4) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(4) effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A).~~

~~3) Hospitals described in subsection (f)(5) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(5) at the beginning of each rate period described in Section 148.25(g)(2)(B).~~

~~4) Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.~~

~~5) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election has been made, the hospital may not later in that rate period elect to be reimbursed under any other methodology.~~

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6) ~~Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG-PPS may not later elect to be reimbursed at rates stated in such contracts.~~

h) ~~Notification of Reimbursement Methodology~~

1) ~~Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.~~

2) ~~Hospitals described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) of this Section shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) shall have 30 days after the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within 30 days after the date of notification, as described in this Section, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in subsection (g) of this Section.~~

e) Zero Balance Bills. The Department requires a hospital to submit a bill for any inpatient service provided to an individual enrolled in any of the Medical Assistance Programs administered by the Department, Illinois Medicaid eligible person, including newborns, regardless of payer-payor. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the Department's liability on the claim. The Department requires that zero balance bills be submitted subsequent to discharge in the same manner as are other bills so that information may be available for the maintenance of accurate patient profiles and diagnosis-related grouping (DRG) data, and information needed for calculation of disproportionate share and other rates. The provisions of this subsection apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.50 Covered Hospital Services

Effective for dates of service on or after July 1, 2014:

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- a) The Department shall pay hospitals for the essential provision of inpatient, outpatient, and clinic diagnostic and treatment services not otherwise excluded or limited which are provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), and which are provided in compliance with hospital licensing standards. Payment may be made for the following types of care subject to the special requirements described in Section 148.40:
- 1) General/specialty services.†
 - 2) Psychiatric services.†
 - 3) Rehabilitation services.† and
 - 4) End-Stage Renal Disease Treatment (ESRDT) services.
- b) Certain services programs are defined ~~administered~~ as hospital covered services with certain restrictions. These programs include hospital residing long term care services, subacute alcoholism and substance abuse treatment services, and the transplant program.
- c) Hospital Residing Long Term Care Services
- 1) Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is enrolled with the Department to provide hospital residing long term care:
 - A) A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or
 - B) A special unit or separate facility administratively associated with the hospital and licensed as a long term care facility.

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- 2) There are three categories of service for hospital residing long term care. These categories are as follows:
- A) Skilled Care – Hospital Residing (category of service 037)
Reimbursement is available for hospitals providing hospital residing long term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:
- i) The hospital must document its attempt to place the patient in at least five appropriate facilities.
 - ii) Documentation (form ~~HFS 3127DPA-3127~~) must be attached to the appropriate claim form and submitted to the Department.
 - iii) Reimbursement is limited to services provided after the minimum number of contacts ~~has have~~ been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement ~~may will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.
- B) Exceptional Care – Hospital Residing (category of service 038)
Reimbursement is available for hospitals providing hospital residing long term care when the level of care is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition, head injured persons, and ventilator dependent persons.

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Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

- i) The ~~hospital~~ ~~hospital~~ must document its attempt to place the patient in at least five appropriate facilities.
- ii) Documentation (form ~~HFS 3127~~ ~~DPA-3127~~) must be attached to the appropriate claim form and submitted to the Department.
- iii) Reimbursement is limited to services provided after the minimum number of contacts ~~has~~ ~~have~~ been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement ~~may~~ ~~will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

- C) ~~IDDD~~ MI Non-Acute Care – Hospital Residing (category of service ~~0~~39)

Reimbursement is available for hospitals providing hospital residing long term care when the pre-admission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide ~~DD/MI~~ rate for intermediate care facilities for persons with intellectual disabilities. For a hospital to be eligible for such reimbursement, the following criteria must be met:

- i) The hospital must document that the pre-admission screening agent has not completed the assessment, planning or discharge process.
- ii) Reimbursement is limited to a maximum of three non-acute level of care days. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary.

- d) Sub-acute Alcoholism and Substance Abuse Treatment Services

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- 1) ~~Subacute alcoholism and other substance abuse treatment is a covered service for clients under Title XIX (Medicaid) and for children 13 to or through 18 years of age in Family and Children Assistance cases in the City of Chicago.~~
 - 2) ~~Only acute alcoholism and substance abuse treatment services (detoxification) are covered as hospital services.~~ Rules Regulations regarding reimbursement for subacute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.
- e) Transplant Program
The Medical Assistance Program provides for payment for organ transplants only when provided by a certified transplantation center as described in Section 148.82. Payment for kidney and cornea transplants does not require enrollment as an approved transplantation center. ~~Payment for kidney and cornea transplants is made in accordance with the appropriate methodology described in Sections 148.160, 148.170, 148.250 through 148.300, or 89 Ill. Adm. Code 149.100 and 149.150. Kidney acquisition costs shall be reimbursed in accordance with 89 Ill. Adm. Code 149.150(c)(5). Payment for bone marrow, heart, liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered and reimbursed in accordance with Section 148.82 provided the hospital is certified by the Department to perform the transplant.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.60 Services Not Covered as Hospital Services

Effective for dates of service on or after July 1, 2014:

Certain services, although included in the Medical Assistance Program and under certain circumstances provided in the hospital setting or by an entity associated with the hospital, are not reimbursed by the Department as hospital services. In addition, certain services currently provided in the hospital outpatient and hospital-based clinic setting are subject to fee-for-service payment methodologies. This means that for these services, hospitals shall be required to conform to the policies and billing procedures in effect for other non-hospital providers of services. Payment for these services shall be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting. Services not covered or reimbursed as hospital services are as follows:

- a) Private Duty Nursing Services. Private duty nursing services for hospitalized program participants are not covered under the Medical Assistance Program. Hospitals are expected to provide all required nursing services.

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- b) Sitter Services. Sitter services for hospitalized program participants are not covered under the Medical Assistance Program.
- c) Dental Services. Hospitals may not enroll to provide dental services. When dental services are provided in the outpatient/clinic setting of a hospital, the dentist shall submit charges to the Department according to the provisions of the Dental Program.
- d) Nurse Anesthetist Services. Payment for general anesthesia services not reimbursed under 89 Ill. Adm. Code 140.400 shall be made only to hospitals that qualify for these payments under the Medicare Program (~~Social Security Act, Title XVIII~~) and shall be made to such hospitals when provided by a hospital employed non-physician anesthetist (~~certified registered nurse anesthetist Certified Registered Nurse Anesthetist~~ or "CRNA").
- e) Pharmacy Services. Policy and reimbursement for pharmacy services are described in 89 Ill. Adm. Code 140.440 through 140.450. A hospital pharmacy may enroll on a fee-for-service basis for services provided to a patient in:
 - 1) A specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program.;
 - 2) A special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility.;
 - 3) The outpatient/clinic setting when the services provided are not unique to the hospital setting.
- f) Medical Transportation Services. A hospital that owns and operates medical transportation vehicles as a separate entity (for example, a private corporation) must enroll as a medical transportation provider. A hospital that owns and operates medical transportation vehicles that are included on the hospital's cost report as a cost center of the hospital may not submit a separate claim for transportation services provided to persons admitted as inpatients. Policy and reimbursements for medical transportation services is described in 89 Ill. Adm. Code 140.490 through 140.492.
- g) Home Health Services. ~~Home health services are not considered by the Department to be hospital services.~~—A home health agency that is administratively associated with a hospital and that is certified for participation as a home health agency by the Medicare Program may apply for participation for the provision of

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home health services. Policy and reimbursement for home health services is described in 89 Ill. Adm. Code 140.470 through 140.474.

- h) Sub-acute Alcoholism and Substance Abuse Treatment Services. Only acute alcoholism and substance abuse treatment services (i.e., detoxification) are covered as hospital services. ~~Rules~~Regulations regarding reimbursement for sub-acute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.
- i) Hospice Services. Hospice is an alternative to traditional Medicaid coverage. The Hospice Program is responsible for all the client's medical needs related to a terminal illness. If a client chooses the Hospice Program, a physician must certify that the client is terminally ill and has a life expectancy of six months or less. Policy and reimbursement for hospice services is described in 89 Ill. Adm. Code 140.469.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.70 Limitation On Hospital Services

Effective for dates of service on or after July 1, 2014:

- a) Payment for inpatient hospital care in general and specialty hospitals, including psychiatric hospitals, shall be made only when it is recommended by a qualified physician, and the care is essential as determined by the appropriate utilization review authority. For hospitals or distinct part units reimbursed on a per diem basis under Sections 148.105 through 148.115 and 148.160 through 148.170 ~~and 148.250 through 148.300~~, payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority (see Section 148.240). If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.
- b) For hospitals ~~or distinct part units~~ reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code Part 149.
- c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.105 through 148.115 and 148.160 through 148.170 ~~and 148.250 through 148.300~~, payment for inpatient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one

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day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.

- ~~d)~~ ~~In obstetrical cases, payment for services to both the mother and the newborn child shall be made at one per diem rate, or one per case rate, whichever is applicable. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name separately.~~
- de) Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section 148.25(d)(1), 89 Ill. Adm. Code 149.50(e)(1), shall be made only when such services have been provided in accordance with federal regulations at 42 CFR 441, subparts C and D.
- ef) Payment for transplantation costs (with the exception of kidney and cornea transplants), including organ acquisition costs, shall be made only when provided by an approved transplantation center as described in Section 148.82. Payment for kidney and cornea transplantation costs does not require enrollment as an approved transplantation center ~~and is only provided to hospitals reimbursed on a per-case basis in accordance with 89 Ill. Adm. Code 149.~~
- fg) ~~Effective with inpatient hospital admissions on or after July 1, 2012, the~~ The Department shall reduce the payment for a claim that indicates the occurrence of a provider preventable condition during the admission as specified in this subsection (fg).
- ~~1)~~ ~~Until such time as the All Patient Refined Diagnosis Related Groups (APR-DRG) is implemented by the Department in rule, as authorized by Section 14-11 of the Public Aid Code, the Department shall reduce each claim that indicates the occurrence of a health care acquired condition (HAC) by \$900.~~
- 12) ~~After the APR-DRG is implemented by the Department in rule, as authorized by Section 14-11 of the Public Aid Code, the~~ The Department shall reduce each claim by the amount that the payment on the claim is increased directly due to the occurrence of and treatment for a healthcare acquired condition the (HAC).
- 23) The Department shall not pay for services related to Other Provider Preventable Conditions (OPPCs).

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34) For HACs, hospitals shall code inpatient claims with a Present on Admission (POA) indicator for principal and secondary diagnosis codes billed. For OPPCs, hospitals shall submit claims to report these incidents and will be instructed to populate the inpatient claims with specific supplementary diagnosis coding.

45) Definitions. As used in this subsection ~~(f)(g)~~, the following terms are defined as follows:

"Provider Preventable Condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 (2012) or an Other Provider Preventable Condition.

"Other Provider Preventable Condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

h) Payment for caesarean sections shall be at the normal vaginal delivery rate unless a caesarean section is medically necessary.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.82 Organ Transplant Services

Effective for dates of service on or after July 1, 2014:

a) Introduction
The Department ~~of Public Aid~~ will cover organ transplants as identified under subsection (b) of this Section that are provided to United States citizens or aliens who are lawfully admitted for permanent residence in the United States under color of law pursuant to 42 USC 1396a(a) and 1396b(v). Such services must be provided by certified organ transplant centers which meet the requirements specified in subsections (c) through ~~(g)~~ of this Section.

b) Covered Services

1) Inpatient heart, heart/lung, lung (single or double), liver, pancreas or kidney/pancreas transplantation. Inpatient bone marrow transplants, inpatient and outpatient stem cell transplants.

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- 2) Inpatient intestinal (small bowel or liver/small bowel) transplantation for children only (see subsection (d)(1)(H) of this Section).
- 3) Other types of transplant procedures may be covered when a hospital has been certified by the Department as a transplant center eligible to perform such transplants. Centers must complete the certification process established in subsection (c) of this Section and provide the necessary documentation of the number of transplant procedures performed and the survival rates.
- 4) Medically necessary work-up.

c) Certification Process

- 1) In order to be certified to receive reimbursement for transplants performed on Medical Assistance ~~and KidCare~~ patients, the hospital must:
 - A) Request an application from the Bureau of Comprehensive Health Services.;
 - B) Submit a completed application to the Department for the type of transplant for which the center is seeking certification.;
 - C) Meet certification criteria established in subsection (d) of this Section, ~~based upon review and recommendation of each application by the State Medical Advisory Committee (SMAC); and~~
 - D) Submit a detailed status report on each patient for the type of transplant for which the hospital is seeking certification. Such reports must include the patient's diagnosis, date of transplant, the length of hospitalization, charges, survival rates, patient-specific transplant outcome, and complications (including cause of death, if applicable) for all transplants performed in the time frames required for the type of transplant indicated in subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) of this Section. To protect the privacy of patients included in this report, names of patients who are not covered under Medical Assistance ~~or KidCare~~ are not required.

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- 2) The Department shall notify the hospital of approval or denial of the hospital as a transplant center for Medical Assistance ~~and KidCare~~-eligible patients.
 - 3) In the event the Department receives a request for prior approval to provide a service from a hospital not formally certified under this Section, the Department may approve the request if it determines that circumstances are such that the health, safety and welfare of the recipient would best be served by receiving the service at that hospital. In making its determination, the Department shall take into account the ~~ability and qualifications of the hospital~~ hospital's and its medical ~~staff's ability and qualifications~~ to provide the service, the burden on the recipient's family if a certified hospital is a great distance from their home, and the urgent nature of the transplant.
 - 4) A joint application combining the statistical data for the adult and pediatric programs from two affiliated hospitals that share the same surgeons may be submitted for review ~~by the State Medical Advisory Committee~~. The hospitals must meet the criteria under subsections (d)(1)(A), (B), (K), (L), (M), (N), (O), (P) and (Q), the applicable criteria under subsections (d)(1)(C), (D) or (J) and (d)(1)(R), subsections (d)(2), (3) and (4), and subsection (e) of this Section for certification and recertification.
- d) Certification Criteria
- 1) Hospitals seeking certification as a transplant center shall submit documentation to verify that:
 - A) The hospital is capable of providing all necessary medical care required by the transplant patient. ~~;~~
 - B) The hospital is affiliated with an academic health center. ~~;~~
 - C) The hospital has had the transplant program for inpatient adult heart and liver transplants in operation for at least three years with 12 transplant procedures per year for the past two years and 12 cases in the three-year period preceding the most current two-year period for adult heart and liver transplants. ~~;~~
 - D) The hospital has had the transplant program for inpatient adult heart/lung and lung transplants in operation for at least three years

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with ten transplant procedures per year for the past two years and ten cases in the three-year period preceding the most current two-year period for adult heart/lung and lung transplants.

- E) A hospital specializing in inpatient pediatric heart/lung and lung transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.
- F) The hospital has had the transplant program for inpatient adult and pediatric bone marrow transplants in operation for at least two years with 12 transplant procedures per year for the past two years.
- G) The hospital performing outpatient adult and pediatric stem cell transplants must be part of a certified inpatient program and must have been in operation for at least two years with at least 12 outpatient stem cell transplant procedures per year in the past two years.
- H) A hospital specializing in inpatient pediatric heart or liver transplants, or both, has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.
- I) A hospital specializing in inpatient pediatric intestinal (small bowel or liver/small bowel) transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.
- J) A hospital specializing in inpatient kidney/pancreas and/or pancreas transplants has had the transplant program in operation for at least three years with 25 kidney transplant procedures per year for the past two years and 25 cases in the three-year period preceding the most current two-year period, and five pancreas transplant procedures per year for the past two years and five in the three year period preceding the most current two-year period, or 12 kidney/pancreas transplant procedures per year for the past two years and 12 in the three-year period preceding the most current two-year period.

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- K) The hospital has experts, on staff, in the fields of cardiology, pulmonology, anesthesiology, immunology, infectious disease, nursing, social services, organ procurement, associated surgery and internal medicine to complement the transplant team. In addition, in order to qualify as a transplant center for pediatric patients, the hospital must also have experts in the field of pediatrics.⚠
- L) The hospital has an active cardiovascular medical and surgical program as evidenced by the number of cardiac catheterizations, coronary arteriograms and open heart procedures per year for heart and heart/lung transplant candidates.⚠
- M) The hospital has pathology resources that are available for studying and reporting the pathological responses for transplantation as supported by appropriate documentation.⚠
- N) The hospital complies with applicable State and federal laws and regulations.⚠
- O) The hospital participates in a recognized national donor procurement program for organs or bone marrow provided by unrelated donors, abides by its rules, and provides the Department with the name of the national organization of which it is a member.⚠
- P) The hospital has an interdisciplinary body to determine the suitability of candidates for transplantation as supported by appropriate documentation.⚠
- Q) The hospital has blood bank support necessary to meet the demands of a certified transplant center as supported by appropriate documentation.⚠~~and~~
- R) The hospital meets the applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department:
 - i) A one-year survival rate of 50 percent for inpatient bone marrow and inpatient and outpatient stem cell transplant patients.⚠

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- ii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for heart transplant patients.†
 - iii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for liver transplant patients.†
 - iv) A one-year survival rate of 90 percent for kidney transplant and a one-year survival rate of 80 percent for pancreas transplant; or a one-year survival rate of 80 percent for kidney/pancreas transplant.†
 - v) A one-year survival rate of 65 percent and a two-year survival rate of 60 percent for heart/lung and lung (single or double) transplant patient.†
 - vi) A one-year survival rate of 60 percent and a two-year survival rate of 55 percent for intestinal transplants (small bowel or liver/small bowel).
- 2) The commitment of the hospital to support the transplant center must be at all levels as evidenced by such factors as financial resources, allocation of space and the support of the professional staff for the transplant program and its patients. The hospital must submit appropriate documentation to demonstrate that:
- A) Component teams are integrated into a comprehensive transplant team with clearly defined leadership and responsibility.†
 - B) The hospital safeguards the rights and privacy of patients.†
 - C) The hospital has adequate patient management plans and protocols to meet the patient and hospital's needs.
- 3) The hospital must identify, in writing, the director of the transplant program and the members of the team as well as their qualifications. Physician team members must be identified as board certified, in preparation for board certification, or pending board certification, and the transplant coordinator's name must be submitted.
- 4) The hospital must provide patient selection criteria including indications and contraindications for the type of transplant procedure for which the facility is seeking certification.

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e) Recertification Process/Criteria

- 1) The Department will conduct an annual review for certification of transplant centers. A certified center must submit documentation established under subsections (c), (d), (f) and ~~(g)(h)~~ of this Section ~~for review by the Department's State Medical Advisory Committee~~ for recertification as a transplant center.
- 2) Survival rates of previous transplant patients must be documented prior to certification. The center must maintain patient volume in the year of certification based on previous transplant statistics.
- 3) The Department shall notify the hospital of approval or denial of the recertification of the hospital as a transplant center.
- 4) If the hospital has previously met the requirements for certification or recertification of its program under subsections (d)(1)~~(K), (K)~~, (L), (M), (N), (O), (P) and (Q) and (d)(2), (3) and (4) of this Section and the program has experienced no changes under the above subsections, as evidenced in written documentation on the hospital's application, the hospital will not be required to resubmit the same data.
- 5) If a center has previously met the requirements for certification or recertification of its program under subsections (d)(1)~~(K)~~, (L), (M), (N), (O), (P), (Q) and (R)(i) through (R)(vi), but has performed fewer than the required number of transplants pursuant to subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) as appropriate, the Department may recertify the center if it determines that the best interests of the Medical Assistance ~~or KidCare~~ client eligible for transplant services would be served by allowing continued certification of the center. Criteria the Department may consider in making such a determination include, but are not limited to:
 - A) Not recertifying a center would limit the accessibility of available organs.
 - B) Other centers are not accepting new patients or ~~having have~~ extensive waiting lists.
 - C) The distance to other eligible centers would jeopardize the client's opportunity to receive a viable organ/tissue transplant.

f) Notification of Transplant

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- 1) The hospital must notify the Department prior to performance of the transplant procedure. The notification letter must be from a physician on the transplant team.
- 2) The notification must include the admission diagnosis and pre-transplant diagnosis.
- 3) The Department shall notify the hospital regarding receipt of the notification and provide the appropriate outcome summary forms to the hospital.

g) **Reimbursement**

- 1) ~~Hospital services rendered for transplant procedures under this Section are exempt from the provisions of Sections 148.250 through 148.330 and 89 Ill. Adm. Code 149 of the Department's administrative rules governing hospital reimbursement. Hospital reimbursement for transplants covered within this Section is an all-inclusive rate for the admission, regardless of the number of days of care associated with that admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for a maximum number of days listed below for specific types of transplants:~~
 - A) ~~30 consecutive days of post-operative inpatient care for heart, heart/lung, lung (single or double), pancreas, or kidney/pancreas transplant; or~~
 - B) ~~40 consecutive days of post-operative inpatient care for liver transplant; or~~
 - C) ~~50 consecutive days of post-operative inpatient care for bone marrow transplant (this includes a maximum of seven days prior to the transplant for infusion of chemotherapy), or 50 consecutive days of care for an inpatient or outpatient stem cell transplant; or~~
 - D) ~~70 consecutive days of post-operative inpatient care for intestinal (small bowel or liver/small bowel) transplants; or~~
 - E) ~~For those transplants covered under subsection (b)(2) of this Section, the number of consecutive days of inpatient care specified within the transplant certification process.~~

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- ~~2) Reimbursement will be approved only when the Department's letter acknowledging the notification of the transplant procedure is attached to the hospital's claim. Reimbursement will not be made until the discharge summary has been submitted to the Department.~~
 - ~~3) Applicable disproportionate share payment adjustments shall be made in accordance with Section 148.120(g). Applicable outlier adjustments shall be made in accordance with Section 148.130. Applicable Medicaid High Volume adjustments shall be made in accordance with Section 148.290(d).~~
 - ~~4) The rate will not include transportation and physician fees when reimbursed pursuant to 89 Ill. Adm. Code 140.410 through 140.414 and 140.490 through 140.492, respectively.~~
 - ~~5) Hospital reimbursement for bone marrow searches is limited to 60 percent of charges up to a maximum of \$25,000. Payment for bone marrow searches will only be made to the certified center requesting reimbursement for the bone marrow transplant.~~
 - ~~6) Reimbursement for stem cell acquisition charges which includes the mobilization, chemotherapy, cytokines and apheresis processes must be billed under the appropriate revenue code on the claim submitted for the transplant procedure.~~
- gh) Reporting Requirements of Certified Transplant Center
The following documentation must be submitted within the time limits set forth in this subsection (h).
- 1) Outcome Summary
 - A) The discharge summary for each Medical Assistance ~~and KidCare~~ patient must be received by the Department within 30 days after the patient's discharge.
 - B) For those Medical Assistance ~~and KidCare~~ patients who expire, a summary must be received by the Department within 30 days after the patient's death.
 - 2) Notification of Changes

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The center must notify the Department within 30 days after any changes in its program including, but not limited to, certification criteria, patient selection criteria, members of the transplant team and the coordinator.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.85 Supplemental Tertiary Care Adjustment Payments (Repealed)

- a) ~~Qualifying Criteria. Supplemental Tertiary Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to all qualifying Illinois hospitals. An Illinois hospital shall qualify for payment if it was deemed eligible for payments under the Tertiary Care Adjustment Payments for State fiscal year 2003, 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 [110 ILCS 330], 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~~
 - 1) ~~For the supplemental tertiary care adjustment period occurring in State fiscal year 2004, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296, multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (d) of this Section have been met.~~
 - 2) ~~For the supplemental tertiary care adjustment period occurring in State fiscal year 2005, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296 and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (d) being met, shall be paid within 75 days after the conditions described in subsection (d) have been met.~~
 - 3) ~~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.~~

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e) **Definitions**

- 1) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
 - 2) ~~"Supplemental Tertiary Care Adjustment Period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12 month period beginning July 1 of the year and ending June 30 of the following year.~~
- d) ~~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: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments (Repealed)

- a) ~~Qualifying Criteria: Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments as described in subsection (b) of this Section shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).~~
- b) **MIUR Adjustment Payments**
 - 1) ~~Each qualifying hospital will receive a payment equal to the product of:~~
 - A) ~~The quotient of:~~
 - i) ~~-\$57.25~~
 - ii) ~~divided by the greater of the hospital's MIUR or 1.6 percent, and~~
 - B) ~~The hospital's Medicaid inpatient days in the MIUR base period.~~

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- 2) ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
 - 3) ~~Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or \$10,500,000.~~
- e) ~~Payment to a Qualifying Hospital~~
- 1) ~~For the MIUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.~~
 - 2) ~~For the MIUR adjustment period occurring in State fiscal year 2005, 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 July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions described in subsection (e) have been met.~~
 - 3) ~~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) ~~"MIUR base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
 - 2) ~~"MIUR adjustment period" means, beginning June 1, 2004, the one-month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
 - 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~~

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~~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 MIUR base period that were adjudicated by the Department through June 30, 2002.~~

- 4) ~~"MIUR", for a given hospital, has the meaning as defined in Section 148.120(k)(4) and shall be determined in accordance with Section 148.120(e) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2003 shall be the MIUR used in the MIUR adjustment.~~
 - 5) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~
 - 6) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- e) ~~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: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments
(Repealed)

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- a) ~~Qualifying Criteria. Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments, as described in subsection (b) of this Section, shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).~~
- b) ~~MOUR Adjustment Payments~~
 - 1) ~~Each qualifying hospital will receive a payment equal to the product of:~~
 - A) ~~The quotient of:~~
 - i) ~~the hospital's Medicaid outpatient charges in the MOUR base period~~
 - ii) ~~divided by the greater of the hospital's MOUR or 1.6 percent, and~~
 - B) ~~2.45 percent.~~
 - 2) ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
 - 3) ~~Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or \$6,750,000.~~
- e) ~~Payment to a Qualifying Hospital~~
 - 1) ~~For the MOUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (c) of this Section have been met.~~
 - 2) ~~For the MOUR adjustment period occurring in State fiscal year 2005, 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 July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described~~

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~~in subsection (e) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.~~

- 3) ~~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) ~~"Total outpatient charges" means, for a given hospital, the gross outpatient revenue as reported on form CMS 2552-96, Worksheet G-2, Part I, row 25, column 2, for hospital fiscal years ending in calendar year 2001 as filed in the March 2003 release of the Healthcare Cost Reporting Information System (HCRIS). If information was not available for hospitals on the HCRIS, the Department may obtain the gross outpatient charges from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~
- 2) ~~"MOUR base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
- 3) ~~"MOUR adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- 4) ~~"MOUR", for a given hospital, means the ratio of Medicaid outpatient charges to total outpatient charges.~~
- 5) ~~"Medicaid outpatient charges" means, for a given hospital, the sum of charges for ambulatory procedure listing services as described in Section 148.140(b), excluding charges for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover charges), as tabulated from the Department's paid claims data for services occurring in the MOUR base year that were adjudicated by the Department through September 12, 2003.~~
- 6) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed~~

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~~days is not reported on the Annual Survey of Hospitals, then the Department of Public Aid may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

- 7) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- e) ~~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: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.100 County Trauma Center~~Outpatient Rural Hospital~~ Adjustment Payments

Effective for dates of service on or after July 1, 2014:

- a) County Trauma Center Adjustment (TCA) Payments. Illinois hospitals that on the first day of July, preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows: ~~Qualifying Criteria. Outpatient Rural Hospital Adjustment Payments, as described in subsection (b) of this Section, shall be made to qualifying Illinois rural hospitals, as described in Section 148.25(g)(3), excluding:~~
- 1) The available funds from the Trauma Center Fund each quarter shall be divided by the number of each eligible hospital's (as defined in subsection (a)(4)) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter. ~~County-owned hospitals as described in Section 148.25(b)(1)(A).~~

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- 2) The TCA payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Illinois Public Aid Code. Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).
- 3) The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis. A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).
- 4) Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this Section shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or Level II trauma center as required for the adjustments described in subsection (a)(1) of this Section. In these instances, the adjustments calculated under this subsection shall be pro-rated as applicable, based upon the date that such recognition ceased.
- b) Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments in this Section are as follows: ~~Outpatient Rural Hospital Adjustment Payments~~
 - 1) “Available funds” means funds that have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and have been appropriated by the Illinois General Assembly. Each qualifying hospital's outpatient services for the outpatient rural base period will be divided by the sum of all qualifying hospitals' outpatient services for the outpatient rural base period.
 - 2) “Medicaid trauma admission” means for discharges through June 30, 2014, those services provided to Medicaid-enrolled beneficiaries that were received and processed as hospital inpatient admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: This ratio will be multiplied by \$14,500,000 to determine the hospital's ~~Outpatient Rural Hospital Adjustment Payment.~~

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800.0 through 800.99; 801.0 through 801.99; 802.0 through 802.99; 803.0 through 803.99; 804.0 through 804.99; 805.0 through 805.98; 806.0 through 806.99; 807.0 through 807.69; 808.0 through 808.9; 809.0 through 809.1; 828.0 through 828.1; 839.0 through 839.3; 839.7 through 839.9; 850.0 through 850.9; 851.0 through 851.99; 852.0 through 852.59; 853.0 through 853.19; 854.0 through 854.19; 860.0 through 860.5; 861.0 through 861.32; 862.8; 863.0 through 863.99; 864.0 through 864.19; 865.0 through 865.19; 866.0 through 866.13; 867.0 through 867.9; 868.0 through 868.19; 869.0 through 869.1; 887.0 through 887.7; 896.0 through 896.3; 897.0 through 897.7; 900.0 through 900.9; 902.0 through 904.9; 925; 926.8; 929.0 through 929.99; 958.4; 958.5; 990 through 994.99.

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For discharges after June 30, 2014, those services provided to Medicaid-enrolled beneficiaries that were received and processed as hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June, preceding the TCA rate period and contained within the Department's paid claims data base, and has been grouped to one of the following DRGs:

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020 Craniotomy for trauma.

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055 Head trauma, with coma lasting more than one hour or hemorrhage.

056 Brain contusion/laceration and complicated skull fracture, coma less than one or no coma

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057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.

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135 Major chest and respiratory trauma.

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308 Hip and femur procedures for trauma, except joint replacement.

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384 Contusion, open wound and other trauma to skin and subcutaneous tissue.

910 Craniotomy for multiple significant trauma.

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911 Extensive abdominal/thoracic procedures for multiple significant trauma.

912 Musculoskeletal and other procedures for multiple significant trauma.

930 Multiple significant trauma, without operating room procedure.

3) “TCA base period” means the twelve-month period ending on the last day of June preceding the TCA rate period. For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

4) “TCA rate period” means the twelve-month period beginning on October 1 of the year and ending September 30th of the following year.

5) “Trauma Center Fund” means the fund created in the State treasury by Section 5.325 of the State Finance Act [30 ILCS 105] and described in Section 3.225 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] and Section 5-5.03 of the Public Aid Code [305 ILCS 5].

e) ~~Payment to a Qualifying Hospital~~

1) ~~For the outpatient rural hospital adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (c) of this Section have been met.~~

2) ~~For the outpatient rural hospital adjustment period occurring in State fiscal year 2005, 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 July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (c) being met, shall be paid within 75 days after the conditions described in subsection (c) have been met.~~

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- 3) ~~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) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~
 - 2) ~~"Outpatient rural base period" means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.~~
 - 3) ~~"Outpatient rural adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
 - 4) ~~"Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid-claims data for services occurring in the outpatient rural base period that were adjudicated by the Department through September 12, 2003.~~
 - 5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- e) ~~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~~

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.103 Outpatient Service Adjustment Payments (Repealed)

- a) ~~Qualifying Criteria. Outpatient Service Adjustment Payments, as described in subsection (b) of this Section, shall be made to all Illinois hospitals excluding:~~
- 1) ~~County owned hospitals as described in Section 148.25(b)(1)(A).~~
 - 2) ~~Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], 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 Service Adjustment Payments~~
- 1) ~~An average hospital specific outpatient service rate for the outpatient service base period will be calculated by taking the total payments for outpatient services divided by total outpatient services.~~
 - 2) ~~The average hospital specific outpatient service rate will be multiplied by 75.5 percent and then multiplied by the outpatient services.~~
 - 3) ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
 - 4) ~~Outpatient Service Adjustment Payments will be the lesser of the amount determined in subsection (b)(2) or (b)(3) of this Section or \$3,000,000.~~
- e) ~~Payment to a Qualifying Hospital~~
- 1) ~~For the outpatient service adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions in subsection (c) of this Section have been met.~~

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- 2) ~~For the outpatient service adjustment period occurring in State fiscal year 2005, total annual 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 July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in subsection (c) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.~~
- 3) ~~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) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~
 - 2) ~~"Outpatient service base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
 - 3) ~~"Outpatient service adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
 - 4) ~~"Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient service base period that were adjudicated by the Department through September 12, 2003.~~
 - 5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- e) ~~Payment Limitations: Payments under this Section are not due and payable until:~~

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- 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: Repealed at 38 Ill. Reg. _____, effective _____)

**Section 148.105 Reimbursement Methodologies For Inpatient Rehabilitation Services
Psychiatric Adjustment Payments**

Effective for dates of service on or after July 1, 2014;

- a) Inpatient rehabilitation services not excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed through the DRG PPS.
Qualifying Criteria
Psychiatric Adjustment Payments shall be made to a qualifying hospital, as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:
- 1) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in subsection (e)(5) of this Section that is greater than 60 percent.~~
 - 2) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) that is greater than 20 percent; has greater than 325 total licensed beds as described in subsection (e)(2) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 50 percent.~~

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- 3) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 15 percent; has greater than 500 total licensed beds as described in subsection (e)(2) of this Section; has a psychiatric occupancy rate as described in subsection (e)(4) of this Section that is greater than 35 percent; and has total licensed psychiatric beds described in subsection (e)(3) of this Section that is greater than 50.~~
- 4) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 19 percent; has less than 275 total licensed beds as described in subsection (e)(2) of this Section; has fewer than 1,000 total psychiatric care days as described in subsection (e)(8) of this Section; has 40 or fewer total licensed psychiatric beds as described in subsection (e)(3) of this Section; has greater than 6,000 total days as described in subsection (e)(9) of this Section.~~
- 5) ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the Statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has 50 or more total licensed psychiatric beds as described in subsection (e)(3) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 60 percent.~~
- b) Inpatient rehabilitation services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsections (c) or (d), as applicable. The total payment for an inpatient stay will equal the sum of:
- 1) the payment determined in this Section, and

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- ~~2) any applicable adjustments to payment specified in Section 148.290. The following five classes of hospitals are ineligible for Psychiatric Adjustment Payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4) of this Section:~~
- ~~1) Hospitals located outside of Illinois.~~
 - ~~2) Hospitals located inside HSA-6.~~
 - ~~3) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(e)(1).~~
 - ~~4) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(e)(4).~~
 - ~~5) A children's hospital, as described in 89 Ill. Adm. Code 149.50(e)(3).~~
- c) Rehabilitation hospital. Payment for inpatient rehabilitation services provided by a rehabilitation hospital, as defined in Section 148.25(d)(2); Psychiatric Adjustment Payment Rates ← **Formatted: Indent: Left: 0.5", Hanging: 0.5"**
- 1) For which the Department had no inpatient base period claims data, shall be the product of the following:
 - A) 80 percent of weighted average rehabilitation hospital rate and
 - B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i). For a hospital qualifying under subsection (a)(1) of this Section, the rate is \$63.00.
 - 2) For which the Department had inpatient base period claims data, shall be the product of the following: For a hospital qualifying under subsection (a)(2) of this Section that: ← **Formatted: Indent: Left: 1", Hanging: 0.5", Tab stops: 1.5", Left**
 - A) The greater of: Has less than 10,000 total days, the rate is \$78.00.
 - i) the hospital's rehabilitation rate, as determined in subsection (e), and
 - ii) 80 percent of the weighted average rehabilitation hospital rate. ← **Formatted: Indent: Left: 2", Hanging: 0.5"**
 - B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i). Has equal to or greater than 10,000 total days, the rate is \$125.00. ← **Formatted: Indent: Left: 1.5", Hanging: 0.5"**

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- 3) ~~For a hospital qualifying under subsection (a)(3) of this Section, the rate is \$21.00.~~
- 4) ~~For a hospital qualifying under subsection (a)(4) of this Section, the rate is \$38.00.~~
- 5) ~~For a hospital qualifying under subsection (a)(5) of this Section, the rate is \$140.00.~~
- d) Distinct part rehabilitation unit. Payment for inpatient rehabilitation services provided by a distinct part rehabilitation unit, as defined in Section 148.25(c)(2): Payment to a Qualifying Hospital
 - 1) ~~For which the Department had no inpatient base period paid claims data, shall be the product of the following: The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric adjustment payment rate, as described in subsection (e) of this Section, multiplied by total days as described in subsection (e)(9) of this Section.~~
 - A) The arithmetic mean rate for rehabilitation distinct part units.
 - B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).
 - 2) ~~For which the Department had inpatient base period paid claims data, shall be product of the following: The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment period in installments on at least a quarterly basis.~~
 - A) The lesser of:
 - i) The greater of:
 - The distinct part rehabilitation unit rate, as determined in subsection (e), and
 - The arithmetic mean rate for rehabilitation distinct part units
 - ii) The arithmetic mean rehabilitation rate for rehabilitation distinct part units plus the value of one standard deviation of the rehabilitation rate for rehabilitation distinct part units.

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e) The rehabilitation rate is calculated as the sum of:

- 1) The rehabilitation rate as in effect on July 1, 2011.
- 2) The quotient, rounded to the nearest hundredth, of the rehabilitation provider's allocated static payments divided by the rehabilitation provider's inpatient covered days in the inpatient base period paid claims data.

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f) Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to: Psychiatric Adjustment Payments, Rural Adjustment Payments, Outpatient Assistance Adjustment Payments, Safety Net Adjustment Payments, Critical Hospital Adjustment Payments (CHAP), Tertiary Care Adjustment Payments and Pediatric Inpatient Adjustment Payments during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies as outlined in:

<http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, as determined by the Department, allocated to rehabilitation services based on the ratio of rehabilitation claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for rehabilitation payment for services provided in State fiscal years 2015 and 2016.

"Weighted average rehabilitation hospital rate" means the sum of rehabilitation hospital inpatient base period paid claims data total reported payments, excluding DSH and MPA/MHVA, plus rehabilitation hospital total allocated supplemental payments, divided by rehabilitation hospital inpatient base period paid claims data total covered days.

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

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- 3) ~~"Licensed psychiatric beds" means, for a given hospital, the number of psychiatric licensed beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".~~
- 4) ~~"Psychiatric occupancy rate" means, for a given hospital, the psychiatric hospital occupancy rate as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".~~
- 5) ~~"MIUR" for a given hospital, has the meaning as defined in Section 148.120(k)(5), and shall be determined in accordance with Sections 148.120(c) and (f). For purposes of this rulemaking, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment Payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.~~
- 6) ~~"Psychiatric Adjustment Payment base year" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
- 7) ~~"Psychiatric Adjustment Payment period" means, beginning October 1, 2002, the nine-month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
- 8) ~~"Total psychiatric care days" means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Section 148.40(a), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.~~
- 9) ~~"Total days" means, for a given hospital, the sum of days of inpatient hospital services provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for~~

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

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.110 Reimbursement Methodologies For Inpatient Psychiatric Services~~Base-Rate Adjustment Payments~~

Effective for dates of service on or after July 1, 2014:

- a) Inpatient psychiatric services not excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed through the DRG PPS. Qualifying Criteria
- 1) ~~Psychiatric Base Rate Adjustment Payments, as described in subsection (b)(1) of this Section, shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding:~~
- A) ~~County owned hospitals as described in Section 148.25(b)(1)(A).~~
- B) ~~Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~
- C) ~~A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
- 2) ~~Psychiatric Base Rate Adjustment Payments described in subsection (b)(2) of this Section shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).~~
- b) Inpatient psychiatric services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsections (c) or (d), as applicable. The total payment for an inpatient stay will equal the sum of:

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- 1) the payment determined in this Section, and
- 2) any applicable adjustments to payment specified in Section 148.290. Psychiatric Base Rate Adjustment Payments
- 4) ~~For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay an amount equal to \$400.00 less the hospital's per diem rate for Medicaid inpatient psychiatric services in effect on October 1, 2003, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period. In no event, however, shall that amount be less than zero.~~
- 2) ~~For a hospital qualifying under subsection (a)(2) of this Section, whose inpatient psychiatric per diem rate in effect on October 1, 2003 is greater than \$400.00, the Department shall pay an amount equal to \$25.00 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period.~~
- 3) ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) or (b)(2) shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
- c) Psychiatric hospital. Payment for inpatient psychiatric services provided by a psychiatric hospital, as defined in Section 148.25(d)(1); Payment to a Qualifying Hospital
 - 1) For which the Department had not inpatient base period paid claims data, shall be the product of: For the psychiatric base rate adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.
 - A) The lowest hospital psychiatric rate determined pursuant to subsection (e); and
 - B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).
 - 2) For which the Department had inpatient base period paid claims data, shall

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~~be the product of the following: For the psychiatric base rate adjustment period occurring in State fiscal year 2005, 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 July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.~~

~~A) The hospital's psychiatric rate, as determined in subsection (e).~~

~~B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).~~

~~3) 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) Distinct part psychiatric unit. Payment for psychiatric services provided by a distinct part psychiatric unit, as defined in Section 148.25(c)(1): ~~Limitations: Hospitals that qualify for Psychiatric Base Rate Adjustment Payments shall not be eligible for the total Psychiatric Base Rate Adjustment Payment if, during the psychiatric base rate adjustment period, the hospital no longer operates the psychiatric distinct part unit.~~

~~1) For which the Department had no inpatient base period paid claims data, shall be the product of the following:~~

~~A) 80 percent of the arithmetic mean transition rate for psychiatric distinct part units, and~~

~~B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).~~

~~2) For which the Department had inpatient base period paid claims data, shall be the product of the following:~~

~~A) The lesser of:~~

~~i) The greater of:~~

- ~~• The distinct part psychiatric unit rate, as determined in subsection (e), and~~

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- 80 percent of the arithmetic mean psychiatric rate for psychiatric distinct part units.
 - ii) The arithmetic mean r rate for psychiatric distinct part units plus the value of two standard deviations of the psychiatric rate for psychiatric distinct part units.
- e) The psychiatric rate is calculated as the sum of:
- 1) The per diem rate for psychiatric services in effect on July 1, 2011.
 - 2) The quotient, rounded to the nearest hundredth, of the psychiatric provider's allocated static payments divided by the psychiatric provider's inpatient covered days in the inpatient base period paid claims data.

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f) Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to Sections 148.105, 148.115, 148.117, 148.126, 148.295, 148.296 and 148.298 during the State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies as outlined in: <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.a.spx>, as determined by the Department, allocated to psychiatric services based on the ratio of psychiatric claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for psychiatric payment for services provided in State fiscal years 2015 and 2016.

- 1) "Psychiatric base rate period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.
- 2) "Psychiatric base rate adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 3) "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,

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~~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, 2002.~~

4) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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 38 Ill. Reg. _____, effective _____)

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Section 148.112 Medicaid High Volume Adjustment Payments

Effective for dates of service on or after July 1, 2014:

- a) The Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that are eligible to receive the adjustment payments described in Section 148.122. Qualifying criteria. 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 did not qualify for disproportionate share adjustments as described in Section

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~~148.120 for the rate year 2003 determination and provided more than 20,000 Medicaid inpatient days in the high volume base period.~~

- b) ~~Calculation of Medicaid High Volume Adjustments 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) ~~A children's hospital, as defined in Section 148.25(d)(3), shall receive a MHVA payment adjustment of \$120.~~
 - 2) ~~Any hospital other than a children's hospital meeting the criteria specified in subsection (a) shall receive a MHVA payment adjustment of \$60. Hospitals organized under the University of Illinois Hospital Act [140 ILCS 330], as described in Section 148.25(b)(1)(B).~~
 - 3) ~~The amount calculated pursuant to subsections (b)(1) and (b)(2) of this Section, shall be adjusted as authorized in Section 5-5.02 of the Illinois Public Aid Code [305 ILCS 5]. A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
- c) ~~Payment High Volume Adjustment Payments~~
- 1) ~~The adjustments calculated under this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided so long as the hospital meets the criteria specified in subsection (a) on the covered day. For a hospital qualifying under subsection (a) of this Section, the Department shall pay the product of \$190.00 multiplied by the qualifying hospital's Medicaid inpatient days.~~
 - 2) ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (c)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~
 - 3) ~~For hospitals qualifying under subsection (a) of this Section that provided fewer than 30,000 Medicaid inpatient days in the high volume base period, payments will be the lesser of the calculation described in subsection (c)(1) or (c)(2) of this Section or \$3,500,000.~~
- d) ~~Payment to a Qualifying Hospital~~

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- 1) ~~For the high volume adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (c) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.~~
 - 2) ~~For the high volume adjustment period occurring in State fiscal year 2005, 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 July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.~~
 - 3) ~~If a hospital closes during fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~
- e) ~~Definitions-~~
- 1) ~~"High volume base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~
 - 2) ~~"High volume adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~
 - 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 high volume base period that were adjudicated by the Department through June 30, 2002.~~
 - 4) ~~"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital~~

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~~provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

- 5) ~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~
- 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 38 Ill. Reg. _____, effective _____)

**Section 148.115 Reimbursement Methodologies For Long Term Acute Care Services ~~Rural~~
Adjustment Payments**

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Effective for dates of service on or after July 1, 2014:

- a) Inpatient long term acute care psychiatric services excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed under the inpatient psychiatric services methodologies specified in Section 148.110. Qualifying Criteria

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~~Rural Adjustment Payments shall be made to all qualifying general acute care hospitals that are designated as a Critical Access Hospital or a Necessary Provider, as designated by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F (2001), as of the first day of July in the Rural Adjustment Payment rate period.~~

- b) Inpatient long term acute care services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to this Section. The total payment for an inpatient stay will equal the sum of:

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- 1) the payment determined in this Section, and
- 2) any applicable adjustments to payment specified in Section 148.290.

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~~Rural Adjustment Rates~~

~~1) Inpatient Component~~

~~For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment inpatient component shall be calculated as follows:~~

- ~~A) Total inpatient payments, as described in subsection (d)(2) of this Section, shall be divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient payment per day.~~
- ~~B) Total inpatient charges, associated with inpatient days as described in subsection (d)(4) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total inpatient cost.~~
- ~~C) Total inpatient costs, as defined in subsection (b)(1)(B) of this Section, are divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient cost per day.~~
- ~~D) Inpatient payment per day, as defined in subsection (b)(1)(A) of this Section, shall be subtracted from the inpatient cost per day, as described in subsection (b)(1)(C) of this Section, to derive an inpatient cost coverage deficit per day. The minimum result shall be no lower than zero.~~
- ~~E) Inpatient cost coverage deficit per day, as described in subsection (b)(1)(D) of this Section, shall be multiplied by the total inpatient days, as described in subsection (d)(4) of this Section, to derive a total hospital specific inpatient cost coverage deficit.~~
- ~~F) The inpatient cost deficits, as described in subsection (b)(1)(E) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year inpatient cost deficit.~~

~~2) Outpatient Component~~

~~For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment outpatient component shall be calculated as follows:~~

- ~~A) Total outpatient payments, as defined in subsection (d)(3) of this Section, shall be divided by the total outpatient services, as~~

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~~described in subsection (d)(5) of this Section, to derive an outpatient payment per service unit.~~

- ~~B) Total outpatient charges, associated with outpatient services, as defined in subsection (d)(5) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total outpatient cost.~~
- ~~C) Total outpatient costs, as defined in subsection (b)(2)(B) of this Section, are divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient cost per service unit.~~
- ~~D) Outpatient payment per service unit, as defined in subsection (b)(2)(A) of this Section, shall be subtracted from the outpatient cost per service unit, as described in subsection (b)(2)(C) of this Section, to derive an outpatient cost coverage deficit per service unit. The minimum result shall be no lower than zero.~~
- ~~E) Outpatient cost coverage deficit per service unit, as described in subsection (b)(2)(D) of this Section, shall be multiplied by the total outpatient services, as described in subsection (d)(5) of this Section, to derive a total hospital specific outpatient cost coverage deficit.~~
- ~~F) The outpatient cost coverage deficits, as described in subsection (b)(2)(e) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year outpatient cost deficit.~~

3) ~~Payment Methodology~~

~~A \$7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services as follows:~~

- ~~A) The total inpatient cost coverage deficit, as described in subsection (b)(1)(F) of this Section, is added to the total outpatient cost coverage deficit, as described in subsection (b)(2)(F) of this Section, to derive a total Rural Adjustment Payment base year deficit.~~
- ~~B) The inpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total inpatient cost deficit,~~

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~~as described in subsection (b)(1)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.~~

~~C) The outpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total outpatient cost deficit, as described in subsection (b)(2)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.~~

~~D) An inpatient pool allocation shall be the product of the inpatient pool allocation percentage, as described in subsection (b)(3)(B) of this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.~~

~~E) The outpatient pool allocation shall be the product of the outpatient pool allocation percentage, as described in subsection (b)(3)(C) of this Section, multiplied by the \$7 million pool, as described in subsection (b)(3) of this Section.~~

~~F) An inpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the inpatient pool allocation, as described in subsection (b)(3)(D) of this Section, the denominator of which shall be the total inpatient cost deficit as described in subsection (b)(1)(F) of this Section.~~

~~G) An outpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the outpatient pool allocation, as described in subsection (b)(3)(E) of this Section, the denominator of which shall be the total outpatient cost deficit as described in subsection (b)(2)(F) of this Section.~~

~~H) The hospital-specific inpatient cost coverage adjustment amount shall be the product of the inpatient residual cost coverage factor, as described in subsection (b)(3)(F) of this Section, multiplied by the hospital-specific inpatient cost coverage deficit, as described in subsection (b)(1)(E) of this Section.~~

~~I) The hospital-specific outpatient cost coverage adjustment amount shall be the product of the outpatient residual cost coverage factor, as described in subsection (b)(3)(G) of this Section, multiplied by~~

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~~the hospital-specific outpatient cost coverage deficit, as described in subsection (b)(2)(E) of this Section.~~

- c) Payment for long term acute care services provided by a long term acute care hospital, as defined in Section 148.25(d)(4):

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Payment to a Qualifying Hospital

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- 1) For which the Department had no inpatient base period paid claims data, shall be the product of the following: ~~The total annual adjustment amount to a qualified hospital shall be the sum of the hospital-specific inpatient cost coverage adjustment amount, as described in subsection (b)(3)(H) of this Section, plus the hospital-specific outpatient cost coverage adjustment amount, as described in subsection (b)(3)(I) of this Section.~~

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A) \$604.00, and

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B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i)

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- 2) For which the Department had inpatient base period paid claims data, shall be the product of the following: ~~The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (d)(7) of this Section, on at least a quarterly basis.~~

A) The hospital-specific rate, as determined in subsection (d)

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i)

- d) The hospital-specific rate is calculated as the sum of:

1) The per diem rate for long term acute care services in effect on July 1, 2011.

2) The quotient, rounded to the nearest hundredth, of the hospital's allocated static payments divided by the hospital's covered days in the inpatient base period paid claims data.

- ed) Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to Sections 148.105, 148.115, 148.117, 148.126, 148.295 and 148.298

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during State fiscal year 2011 pursuant to the methodologies as outlined in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, as determined by the Department, allocated to long-term acute care services based on the ratio of long-term acute care claim charges, excluding psychiatric claim charges, to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims.

f) Long term acute care supplemental per diem rates.

1) The long term acute care supplemental per diem rates, as authorized under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], shall be the amount in effect as of October 1, 2010.

2) No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.

4) "Hospital cost to charge ratio" means the quotient of the fraction, the numerator of which is the cost as reported on Form CMS 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form CMS 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, and, for SFY 2004, the hospital's fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.

2) "Inpatient payments" shall mean all payments associated with total days provided, as described in subsection (d)(4) of this Section, and all quarterly adjustment payments paid, as described throughout Part 148, excluding the Rural Adjustment Payments described in this Section.

3) "Outpatient payments" shall mean all payments associated with total outpatient services provided, as described in subsection (d)(5) of this Section, and all quarterly adjustment payments paid, as described in this Part, excluding the Rural Adjustment Payments described in this Section.

4) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title

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~~XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~

- 5) ~~"Total outpatient services" means the number of outpatient services provided during the Rural Adjustment Payment base year to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for services occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~
- 6) ~~"Rural Adjustment Payment base year" means, for the Rural Adjustment Payment rate period beginning October 1, 2002, SFY 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, SFY 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.~~
- 7) ~~"Rural Adjustment Payment rate period" means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of that year and ending June 30 of the following year.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.116 Reimbursement Methodologies For Children's Specialty Hospitals

Effective for dates of service on or after July 1, 2014:

- a) Inpatient general acute care services provided by a Children's Specialty Hospital as defined in Section 148.25(i) and excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b), shall per day of covered inpatient care be reimbursed as follows:
 - 1) For a hospital that would not have met the definition of a children's specialty hospital as of July 1, 2013, \$1,400.00 per day.

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- 2) For a hospital that would have met the definition of a children's specialty hospital as of July 1, 2013, a rate equal to the per diem base rate in place on July 1, 2013, multiplied by a factor of 1.37.
- 3) The total payment for inpatient stay will equal the sum of:
 - A) The payment determined in this Section; and
 - B) Any applicable adjustments to payment specified in Section 148.290.
- b) Hospital outpatient and clinic services shall be reimbursed in accordance with Section 148.140.
- c) To ensure access to outpatient care and maintain stability for children's specialty hospitals the Department shall make annual outpatient transitional payments equal to the difference of:
 - 1) The amount of static payments made to the hospital in State fiscal year 2011 in accordance with the Safety Net Adjustment Payments, Critical Hospital Adjustment Payments (CHAP), Tertiary Care Adjustment Payments, Pediatric Outpatient Adjustment Payments and Pediatric Inpatient Adjustment Payments pursuant to the methodologies as outlined in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>; and
 - 2) .8695.
 - 3) The annual amount determined in this Section shall be paid in monthly installments equal to 1/12 of the annual amount.
- d) The reimbursement methodologies in this Section shall be re-determined prior to July 1, 2016 if implementation of reform to hospital non-institutional service reimbursement occurs. In the absence of reform to hospital non-institutional service reimbursement, the reimbursement methodologies in this Section shall be re-determined to be effective on or after July 1, 2016.

(Source: Added at 38 Ill. Reg. _____, effective _____)

Section 148.117 Outpatient Assistance Adjustment Payments

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Effective for dates of service on or after July 1, 2014 except those sections specifically designated otherwise;

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- a) Qualifying Criteria. Outpatient Assistance Adjustment Payments, as described in subsection (b) of this Section, shall be made to Illinois hospitals meeting one of the criteria identified in this subsection (a):

- ~~1)~~ ~~A hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care percentage greater than 70% and has provided greater than 10,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.~~
- 2) A general acute care hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care percentage greater than 85%.
- ~~3)~~ ~~A general acute care hospital that does not qualify for Medicaid Percentage Adjustment Payments for rate year 2007, as defined in Section 148.122, located in Cook County, outside the City of Chicago, has an emergency care percentage greater than 63%, has provided more than 10,750 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year and has provided more than 325 Medicaid surgical group outpatient ambulatory procedure listing services in the outpatient assistance base year.~~
- 24) A general acute care hospital located outside of Cook County that qualifies for Medicaid Percentage Adjustment Payments for rate year 2007 as defined in Section 148.122, is a trauma center recognized by the Illinois Department of Public Health (DPH) as of July 1, 2006, has an emergency care percentage greater than 58%, and has provided more than 1,000 Medicaid Non-emergency/Screening outpatient ambulatory procedure listing services in the outpatient assistance base year.
- ~~35)~~ A hospital that has an MIUR of greater than 50% and an emergency care percentage greater than 80%, and that provided more than 6,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- ~~46)~~ A hospital that has an MIUR of greater than 70% and an emergency care percentage greater than 90%.

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- ~~57~~) A general acute care hospital, not located in Cook County, that is not a trauma center recognized by DPH as of July 1, 2006 and did not qualify for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an MIUR of greater than 25% and an emergency care percentage greater than 50%, and that provided more than 8,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- ~~68~~) A general acute care hospital, not located in Cook County, that is a Level I trauma center recognized by DPH as of July 1, 2006, has an emergency care percentage greater than 50%, and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services, including more than 1,000 non-emergency screening outpatient ambulatory procedure listing services, in the outpatient assistance base year.
- ~~79~~) A general acute care hospital, not located in Cook County, that qualified for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an emergency care percentage greater than 55%, and provided more than 12,000 Medicaid outpatient ambulatory procedure listing services, including more than 600 surgical group outpatient ambulatory procedure listing services and 7,000 emergency services in the outpatient assistance base year.
- ~~849~~) A general acute care hospital that has an emergency care percentage greater than 75% and provided more than 15,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- ~~944~~) A rural hospital that has an MIUR of greater than 40% and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- ~~1042~~) A general acute care hospital, not located in Cook County, that is a trauma center recognized by DPH as of July 1, 2006, had more than 500 licensed beds in calendar year 2005, and provided more than 11,000 Medicaid outpatient ambulatory procedure listing services, including more than 950 surgical group outpatient ambulatory procedure listing services, in the outpatient assistance base year.
- ~~13~~) ~~A general acute care hospital located outside of Illinois that provided more than 300 high tech diagnostic Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.~~

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~~14) A general acute care hospital is recognized as a Level I trauma center by DPH on the first day of the OAAP rate period, has Emergency Level I services greater than 2,000, Emergency Level II services greater than 8,000, and greater than 19,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.~~

b) Outpatient Assistance Adjustment Payments

~~1) For hospitals qualifying under subsection (a)(1), the rate is \$139.00.~~

~~2) For hospitals qualifying under subsection (a)(2), the rate is \$850.00 for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is \$1,523.00. For dates of service on or after July 1, 2014, the rate is \$0.00.~~

~~3) For hospitals qualifying under subsection (a)(3), the rate is \$425.00.~~

~~24) For hospitals qualifying under subsection (a)(24), the rate is \$290.00 for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

~~35) For hospitals qualifying under subsection (a)(35), the rate is \$250.00 for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

~~46) For hospitals qualifying under subsection (a)(46), the rate is \$336.25 for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

~~57) For hospitals qualifying under subsection (a)(57), the rate is \$110.00 for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

~~68) For hospitals qualifying under subsection (a)(68), the rate is \$200.00 for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

~~79) For hospitals qualifying under subsection (a)(79), the rate is \$173.50 for dates of service on or after July 1, 2014 through December 31, 2014, through June 30, 2010. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by~~

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~~\$74.00, to \$202.50. For dates of service on or after July 1, 2012 through December 31, 2014, the rate is \$247.50.~~ For dates of service on or after January 1, 2015, the rate is ~~\$0.00~~\$48.50.

~~810)~~ For hospitals qualifying under subsection (a)(~~810~~), the rate is \$135.00 ~~for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by \$70.00, to \$205.00.~~ For dates of service on or after January 1, 2015, the rate is ~~\$0.00~~\$135.00.

~~914)~~ For hospitals qualifying under subsection (a)(~~914~~), the rate is \$65.00 ~~for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

~~1012)~~ For hospitals qualifying under subsection (a)(~~1012~~), the rate is \$90.00 ~~for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

~~13)~~ For hospitals qualifying under subsection (a)(~~13~~) that have an emergency care percentage greater than 19% but less than 25%, the rate is \$141.00. ~~For hospitals qualifying under subsection (a)(13) that have an emergency care percentage greater than 25%, the rate is \$494.00.~~

~~14)~~ For hospitals qualifying under subsection (a)(~~14~~), the rate is \$47.00 ~~for dates of service on or after July 1, 2010 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

c) Payment to a Qualifying Hospital

- 1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by the Medicaid outpatient ambulatory procedure listing services in the outpatient assistance adjustment base year.
- 2) For the outpatient assistance adjustment period for fiscal year 2010 and after, total payments will equal the amount determined using the methodologies described in subsection (c)(1) of this Section and shall be paid to the hospital, at least, on a quarterly basis.
- 3) Payments described in this Section are subject to federal approval.

d) Definitions

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- 1) "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), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006, and the denominator of which is the total ambulatory procedure listing services as described in Section 148.140(b)(1), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006.
- 2) "General acute care hospital" is a hospital that does not meet the definition of a hospital contained in [Section 148.25\(a\) and \(d\)](#)~~89 Ill. Adm. Code 149.50(e)~~.
- 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 assistance base period that were adjudicated by the Department through June 30, 2006.
- 4) "Outpatient assistance year" means, beginning January 1, 2007, the 6-month period beginning on January 1, 2007 and ending June 30, 2007, and beginning July 1, 2007, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
- 5) "Outpatient assistance base period" means the 12-month period beginning on July 1, 2004 and ending June 30, 2005.
- 6) "Surgical group outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(A), excluding services 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 assistance base period that were adjudicated by the Department through June 30, 2006.
- 7) "Non-emergency/screening outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(C)(iii), excluding

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services 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 assistance base period that were adjudicated by the Department through June 30, 2006.

- 8) "High tech diagnostic Medicaid outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services described in Section 148.140(b)(1)(B)(ii), excluding services 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 assistance base period that were adjudicated by the Department through June 30, 2006.
- e) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 must be a Coordinated Care Participating Hospital as defined in Section 148.295(b)(e)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.
- f) No payments shall be made pursuant to this Section for dates of service after December 31, 2014.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.120 Disproportionate Share Hospital (DSH) Adjustments

Effective for dates of service on or after July 1, 2014:

~~Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 2003, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1, thereafter unless otherwise noted.~~

- a) Qualified Disproportionate Share Hospitals (DSH). ~~For inpatient services provided on or after October 1, 2003, the~~ The Department shall make adjustment payments to hospitals that are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

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- 1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in subsection (i)(4) of this Section, is at least one standard deviation above the mean Medicaid utilization rate, as defined in subsection (i)(3) of this Section.
- 2) The hospital's low income utilization rate as defined in subsection (i)(6), exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government funded care) must be added.~~
- b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform nonemergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in Section 148.25(d), 89 Ill. Adm. Code 149.50(e)(1) through (e)(4), must submit a statement to that effect.
- c) In making the determination described in subsection (a)(1) of this Section, the Department shall utilize:
 - 1) Hospital Cost Reports
 - A) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (i)(4) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.
 - B) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited

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cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsection (a)(1) of this Section. Submittal of a corrected cost report in support of subsection (a)(1) of this Section must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's MIUR as described in subsection (i)(4) of this Section.

- C) ~~Hospitals' Medicaid inpatient utilization rates, as defined in subsection (i)(4) of this Section, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(1)(B), hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination. In the event of extensions to the Medicare cost report filing process, those hospitals that do not have an audited or unaudited base year Medicaid cost report on file with the Department by the 30th of April preceding the DSH determination are required to complete and submit to the Department a Hospital Day Statistics Collection (HDSC) form. On the form, hospitals must provide total Medicaid days and total hospital days for the hospital's base fiscal year. The HDSC form must be submitted to the Department by the April 30th preceding the DSH determination.~~
- i) ~~If the Medicare deadline for submitting base fiscal year cost reports falls within the month of June preceding the DSH determination, hospitals, regardless of their base fiscal year end date, will have until the first day of August preceding the DSH determination to submit changes to their Medicaid cost reports for inclusion in the final DSH calculations. In this case, the HDSC form will not be used as a data source for the final rate year DSH determination.~~
- ii) ~~If the Medicare deadline for submitting base fiscal year cost reports is extended beyond the month of June preceding the DSH determination, the HDSC form will be~~

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~~used in the final DSH determination for all hospitals that do not have an audited or unaudited Medicaid cost report on file with the Department. Hospitals will have until the first day of July to submit any adjustments to the information provided on the HDSC form sent to the Department on April 30.~~

~~D) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (i)(4) of this Section, which have been derived from unaudited cost reports or the HDSC form, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsections (e)(1)(B) and (e)(1)(C)(ii) of this Section, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination.~~

~~DE) In the event a subsequent final audited cost report reflects an MIUR, as described in subsection (i)(4) of this Section, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the MIUR based upon the final audited cost report, and recoup any overpayments made if the percentage change in the DSH payment rate is greater than five percent.~~

2) Days Not Available from Cost Report

Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid ~~managed care entity (MCE) Health Maintenance Organization (HMO)~~ days, hospital residing long term care days, and Medicaid days for alcohol and substance abuse ~~sub-acute rehabilitative~~ care under category of service 035. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year.

~~i) For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims~~

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~~data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the following subsection (c)(3)(A)(ii) will not be used in the determination process for DSH determination years on or after October 1, 1996.~~

- ii) ~~For DSH determination years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to the Department due to a determination that the Department had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.~~

- B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.
- C) MCEHMO days. The Department will utilize the Department's MCEHMO claims data available to the Department as of the last day of June preceding the DSH determination year, or specific claim information from each MCE, HMO, for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an MCEHMO.

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- D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.
- E) Alcohol and Substance Abuse Days. The Department will utilize its paid claims data under category of service 35 available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided for alcohol and substance abuse rehabilitative care.
- d) Hospitals may apply for DSH status under subsection (a)(2) of this Section by submitting an audited certified financial statement, for the hospital's base fiscal year, to the Department ~~of Human Services or the Department of Public Aid~~. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:
- 1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
 - 2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
 - 3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, ~~except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance~~), for the hospital's base fiscal year.
 - 4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.
- e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the state in which they are located based upon the federal ~~Federal~~ definition of a DSH hospital (42 U.S.C. 1396r-4[b][1]), ~~as defined in section 1923(b)(1) of the Social Security Act~~, may qualify for DSH hospital adjustments under this Section. For purposes of determining the MIUR, as described in subsection (i)(4) of this Section and as required in the federal

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~~definition (42 U.S.C. 1396r-4[b][1]), section 1923(b)(1) of the Social Security Act,~~ out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the MIUR from their state may submit an audited certified financial statement as described in subsection (d) of this Section. Payments to out-of-state hospitals will be allocated using the same method as described in subsection (g) of this Section.

f) Time Limitation Requirements for Additional Information.

- 1) ~~Except as provided in subsection (e)(1)(C), The the~~ information required in subsections (a), (c), (d) and (e) of this Section must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in subsections (a), (c), (d) and (e) of this Section which is not received or post marked in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.
- 2) The information required in subsection (b) of this Section must be submitted after receipt of notification from the Department. Information required in this Section that is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

g) Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by subsection (a) of this Section shall be calculated annually as follows:

- 1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1), with the exception of any Illinois hospital that is owned or operated by the State or a unit of local government.
 - A) Hospitals qualifying as DSH hospitals under subsection (a)(1) or (a)(2) of this Section will receive an add-on payment to their inpatient rate.
 - B) The distribution method for the add-on payment described in subsection (g)(1) of this Section is based upon a fund of \$5 million. All hospitals qualifying under subsection (g)(1)(A) of this Section will receive a \$5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient

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utilization data (adjusted based upon historical utilization and projected increases in utilization) by \$5. The total dollar amount of this calculation is then subtracted from the \$5 million fund.

- C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) of this Section in proportion to the percentage by which the hospital's MIUR exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate, as described in subsection (i)(3) of this Section. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the \$5 million pool of money available after the \$5 per day base add-on has been subtracted.
- D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C) of this Section, plus the initial \$5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B) of this Section, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day add-on value. Hospitals qualifying under subsection (a)(2) of this Section will receive the minimum adjustment of \$5 per inpatient day. The adjustments calculated under this subsection (g)(1) are subject to the limitations described in subsection (h) of this Section. The adjustments calculated under subsection (g) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

- 2) Department of Human Services (DHS) State-Operated Facility Adjustment for hospitals defined in Section ~~148.25(a)(3)~~~~148.25(b)(6)~~. Department of Human Services State-operated facilities qualifying under subsection (a)(2) of this Section shall receive an adjustment ~~for inpatient services provided on or after March 1, 1995. Effective October 1, 2000, the adjustment payment shall be~~ calculated as follows:

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- A) The amount of the adjustment is based on a State DSH Pool. The State DSH Pool amount shall be the ~~lesser of the~~ federal DSH allotment for mental health facilities as determined in section 1923(h) of the Social Security Act, minus the estimated DSH payments to such facilities that are not operated by the State; ~~or the result of subtracting the estimated DSH payment adjustments made under subsection (g)(1) of this Section and Section 148.170(f)(2) from the aggregate DSH payment allotment as provided for in section 1923(f) of the Social Security Act.~~
 - B) The State DSH Pool amount is then allocated to hospitals defined in Section ~~148.25(a)(3) 148.25(b)(6)~~ that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uncompensated care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uncompensated care costs.
 - C) The adjustment calculated in subsection (g)(2)(B) of this Section shall meet the limitation described in subsection (h)(4) of this Section.
 - D) The adjustment calculated pursuant to subsection (g)(2)(B) of this Section, for each hospital defined in Section ~~148.25(a)(3) 148.25(b)(6)~~ that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in subsection (h) of this Section. The adjustment described in this subsection (g)(2)(D) shall be paid on a quarterly basis.
- 3) Assistance for Certain Public Hospitals
- A) The Department may make an annual payment adjustment to qualifying hospitals in the DSH determination year. A qualifying hospital is a public hospital as defined in section 701(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554).
 - B) Hospitals qualifying shall receive an annual payment adjustment that is equal to:
 - i) A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and

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Protection Act of 2000, section 701(d)(3)(B) for the DSH determination year;

- ii) Divided first by Illinois' Federal Medical Assistance Percentage; and
 - iii) Divided secondly by the sum of the qualified hospitals' total Medicaid inpatient days, as defined in subsection (i)(4) of this Section; and
 - iv) Multiplied by each qualified hospital's Medicaid inpatient days as defined in subsection (i)(4) of this Section.
- C) The annual payment adjustment calculated under this subsection (g)(3), for each qualified hospital, will be divided by four and paid on a quarterly basis.
- D) Payment adjustments under this subsection (g)(3) shall be made without regard to subsections (h)(3) and (4) of this Section, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.
- E) In order to qualify for assistance payments under this subsection (g)(3), with regard to this payment adjustment, there must be in force an executed intergovernmental agreement between the authorized governmental body of the qualifying hospital and the Department.
- 4) Disproportionate Share Payments for Certain Government-Owned or -Operated Hospitals
- A) The following classes of government-owned or -operated Illinois hospitals shall, subject to the limitations set forth in subsection (h) of this Section, be eligible for the Disproportionate Share Hospital Adjustment payment:
- i) Hospitals defined in Section ~~148.25(a)+48.25(b)(1)(A)~~.

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- ii) Hospitals owned or operated by a unit of local government that is located within Illinois and is not a hospital defined in subsection ~~(i)(g)(4)(A)(i)~~ of this Section.
 - ~~iii) Hospital defined in Section 148.25(b)(1)(B).~~
 - B) The annual amount of the payment shall be the amount computed for the hospital pursuant to federal limitations.
 - C) The annual amount shall be paid to the hospital in monthly installments. ~~The portion of the annual amount not paid pending federal approval of payments shall, upon that approval, be paid in a single lump sum payment. Except as indicated in this subsection (g)(4)(C), the annual amount shall be paid to the hospital in 12 equal installments and paid monthly.~~
- h) DSH Adjustment Limitations.
- 1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues provision of nonemergency obstetrical care. The provisions of this subsection (h)(1) shall not apply to those hospitals described in Section 148.25(d) 89 Ill. Adm. Code 149.50(e)(1) through (e)(4) or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987. In this instance, the adjustments calculated under subsection (g)(1) shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.
 - 2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for DSH payment adjustments based upon the requirements of this Section.
 - 3) DSH Payment Adjustment. ~~In accordance with Public Law 102-234, If~~ the aggregate DSH payment adjustments calculated under this Section do not meet the State's final DSH Allotment as determined by the federal

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Centers for Medicare and Medicaid Services, DSH payment adjustments calculated under this Section shall be adjusted to meet the State DSH Allotment. Subject to any limitation, disproportionate share payments will be made to qualifying hospitals in the following order:

- A) ~~Hospitals defined in Section 148.25(a)(3) Psychiatric hospitals operated by the Illinois Department of Human Services~~ – the annual amount shall be credited quarterly via certification of public expenditure.
 - B) Hospitals defined in Section ~~148.25(a)(2)148.25(b)(1)(B)~~.
 - C) Hospitals ~~defined in subsection (g)(4)(A)(ii) of this Section, owned and operated by a unit of local government that is not a hospital defined in Section 148.25(b)(1)(A)~~.
 - D) Hospitals that are not owned or operated by a unit of government – the annual amount shall be paid on each inpatient claim.
 - E) Hospitals defined in Section ~~148.25(a)(1)148.25(b)(1)(A)~~.
- 4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of estimated Medicaid payments (inpatient, outpatient, and disproportionate share) to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. Federal upper payment limit requirements (42 CFR 447.272) shall be considered when calculating the OBRA'93 adjustments. The adjustments shall reduce disproportionate share spending until the costs and spending (described in this subsection (h)(4)) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.
 - 5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's MIUR, as defined in subsection (i)(4) of this Section, is less than one percent.
- i) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

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- 1) "Base fiscal year" means, ~~for example,~~ the hospital's fiscal year ending in the calendar year, 22 months before the beginning of the ~~in 2001 for the October 1, 2003 DSH determination year, the hospital's fiscal year ending in 2002 for the October 1, 2004 DSH determination year, etc.~~
- 2) "DSH determination year" means the 12~~-~~month period beginning on October 1 of the year and ending September 30 of the following year.
- 3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the ~~federal~~Federal Social Security Act (42 USC 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. ~~Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (e)(1) and (e)(2) of this Section.~~ In this subsection (i)(3), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.
- 4) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12~~-~~month period to patients who, for such days, were eligible for Medicaid under Title XIX of the ~~federal~~Federal Social Security Act (42 USC 1396a et seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. ~~Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (e)(1) and (e)(2) of this Section.~~ In this subsection (i)(4), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.
- 5) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.
- 6) "Low income utilization rate" means a fraction, expressed as a percentage that is the sum of:

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- A) The quotient resulting from dividing:
- i) the sum of the total Medicaid revenues paid the hospital under this Section for patient services and cash subsidies for patient services received directly from State and local governments, by
 - ii) the total revenues (including the amount of such cash subsidies) of the hospital for patient services.
- B) The quotient resulting from dividing:
- i) the hospital's charges for inpatient hospital services that are attributable to charity care in a period, (not including contractual allowances and discounts, other than for indigent patients not eligible for Medicaid under an approved State plan) less the portion of any cash subsidies described in subsection (6)(A)(i) reasonably attributable to inpatient hospital services, by
 - ii) total inpatient charges attributable to charity care.

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Section 148.122 Medicaid Percentage Adjustments

Effective for dates of service on or after July 1, 2014:

The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1 of each year ~~October 1, 2003, and each October 1 thereafter~~ unless otherwise noted.

- a) Qualified Medicaid Percentage Hospitals. ~~For inpatient services provided on or after October 1, 2003, The~~ Department shall make adjustment payments to hospitals that are deemed as a Medicaid percentage hospital by the Department. A hospital, except those that are owned or operated by a unit of government, may qualify for a Medicaid Percentage Adjustment in one of the following ways:
- 1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section 148.120(i)(4), is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section 148.120(i)(3).

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- 2) The hospital's low income utilization rate as defined in Section 148.120(i)(6), exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government funded care) must be added.~~
 - 3) Illinois hospitals that, on July 1, 1991, had an MIUR, as defined in Section 148.120(i)(4), that was at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3), and that were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5 1989~~(1989)~~).
 - 4) Illinois hospitals that meet the following criteria:
 - A) Have an MIUR, as defined in Section 148.120(i)(4), that is at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3), ~~and~~
 - B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(3) of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(2) of this Section.
 - 5) Any children's hospital, as defined in Section 148.25(d)(3) ~~89 Ill. Adm. Code 149.50(e)(3)~~.
 - 6) Out of state hospitals meeting the criteria in Section 148.120(e).
- b) In making the determination described in subsections (a)(1) and (a)(4)(A) of this Section, the Department shall utilize the data described in Section 148.120(c) and received in compliance with Section 148.120(f).
 - c) Hospitals ~~that may apply to become a~~ qualified as a Medicaid Percentage Adjustment hospital under subsection (a)(2) for the Medicaid percentage determination year beginning October 1, 2013, may apply annually to become qualified under (a)(2) of this Section by submitting audited certified financial

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statements as described in Section 148.120(d) and received in compliance with Section 148.120(f).

- d) Medicaid Percentage Adjustments. The adjustment payments required by subsection (a) of this Section for qualified hospitals shall be calculated annually as follows for hospitals defined in Section 148.25(b)(1), excluding hospitals defined in Section ~~148.25(a), 148.25(b)(1)(A) and (b)(1)(B).~~
- 1) The payment adjustment shall be calculated based upon the hospital's MIUR, as defined in Section 148.120(i)(4), and subject to subsection (e) of this Section, as follows:
 - A) Hospitals with an MIUR below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$25;
 - B) Hospitals with an MIUR that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$25 plus \$1 for each one percent that the hospital's MIUR exceeds the mean Medicaid inpatient utilization rate;
 - C) Hospitals with an MIUR that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$40 plus \$7 for each one percent that the hospital's MIUR exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and
 - D) Hospitals with an MIUR that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of \$90 plus \$2 for each one percent that the hospital's MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.
 - 2) The Medicaid Percentage Adjustment payment, calculated in accordance with this subsection (d), to a hospital, ~~other than a hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B),~~ shall not exceed \$155 per day for a children's hospital, as defined in ~~Section 148.25(d)(3), 89 Ill. Adm. Code 149.50(e)(3),~~ and shall not exceed \$215 per day for all other hospitals.

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- 3) The amount calculated pursuant to subsections (d)(1) through (d)(2) of this Section shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) hospital cost index from DSH determination year 1993, as defined in Section 148.120(i)(2), through DSH determination year ~~2014~~2003, ~~and annually thereafter~~, by a percentage equal to the lesser of:
 - A) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
 - B) The percentage increase in the Statewide average hospital payment rate, as described in subsection (g)(5) of this Section, over the previous year's Statewide average hospital payment rate.
- 4) The amount calculated pursuant to subsections (d)(1) through (d)(3) of this Section, ~~as adjusted pursuant to subsection (e) of this Section~~, shall be the inpatient payment adjustment in dollars for the applicable Medicaid percentage determination year. The adjustments calculated under subsections (d)(1) through (d)(3) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.
- e) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in ~~Section 148.25(d)(3) 89 Ill. Adm. Code 149.50(e)(3)~~, the payment adjustment calculated under subsection (d)(1) of this Section shall be multiplied by 2.0.
- f) Medicaid Percentage Adjustment Limitations.
 - 1) In addition, to be deemed a Medicaid Percentage Adjustment hospital, a hospital must provide to the Department, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform non-emergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals

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described in ~~Section 148.25(d) 89 Ill. Adm. Code 149.50(e)(1) through (e)(4)~~, must submit a statement to that effect.

- 2) Hospitals that qualify for Medicaid Percentage Adjustments under this Section shall not be eligible for the total Medicaid Percentage Adjustment if, during the Medicaid Percentage Adjustment determination year, the hospital discontinues provision of non-emergency obstetrical care. The provisions of this subsection (f)(2) shall not apply to those hospitals described in ~~Section 148.25(d) 89 Ill. Adm. Code 149.50(e)(1) through (e)(4)~~ or those hospitals that have not offered non-emergency obstetrical services as of December 22, 1987. In this instance, the adjustments calculated under subsection (d) shall cease to be effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.
 - 3) Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for Medicaid Percentage payment adjustments based upon the requirements of this Section.
 - 4) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for Medicaid percentage payment adjustments under this Section shall not be eligible for Medicaid percentage payment adjustments if the hospital's MIUR, as defined in Section 148.120(i)(4), is less than one percent.
- g) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:
- 1) "Medicaid Percentage determination year" ~~has the same meaning as the DSH determination year defined in Section 148.120(i)(2) means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~
 - 2) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4) of this Section, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to

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patients who, for such days, were eligible for Medicaid under Title XIX of the ~~federal Federal~~ Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in subsection (g)(6) of this Section, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the ~~Medicaid percentage~~~~DSH~~ determination year and contained within the Department's paid claims data base.

- 3) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4) of this Section, provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (g)(6) of this Section, provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base.
- 4) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage ~~Adjustment~~ determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, ~~(specifically excluding Medicare/Medicaid crossover claims) with a Diagnosis Related Grouping (DRG) of: 370 through 375, and specifically excludes Medicare/Medicaid crossover claims.~~
 - A) 370 through 375 for claims adjudicated before July 1, 2014, or
 - B) 540, 541, 542, or 560 for claims adjudicated on or after July 1, 2014.
- 5) ~~"Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).~~

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- 56) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (g)(2) and (g)(3) of this Section, means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.
- 67) "Medicaid obstetrical inpatient utilization rate base year" means, ~~the State fiscal year ending 15 months before the for example, fiscal year 2002 for the October 1, 2003, Medicaid Percentage Adjustment determination year; fiscal year 2003 for the October 1, 2004, Medicaid Percentage Adjustment determination year, etc.~~
- 78) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.126 Safety Net Adjustment Payments

Effective for dates of service on or after July 1, 2014, except those sections specifically designated otherwise:

- a) Qualifying criteria: Safety net adjustment payments shall be made to a qualifying hospital, as defined in this subsection (a), unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria:
- 1) The hospital has, as provided in subsection (e)(6) of this Section, an MIUR equal to or greater than 40 percent.
 - 2) ~~The hospital has the highest number of obstetrical care days in the safety net hospital base year.~~
 - 3) ~~The hospital is, as of October 1, 2001, a sole community hospital, as defined by the United States Department of Health and Human Services (42 CFR 412.92).~~

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- ~~24~~) The hospital is, as of October 1, 2001, a rural hospital, as described in Section ~~148.446(a)(1)~~~~148.25(g)(3)~~, that meets all of the following criteria:
- A) Has an MIUR greater than 33 percent.
 - B) Is designated a perinatal level two center by the Illinois Department of Public Health.
 - C) Has fewer than 125 licensed beds.
- ~~5~~) ~~The hospital is a rural hospital, as described in Section 148.25(g)(3).~~
- ~~36~~) The hospital meets all of the following criteria:
- A) Has an MIUR greater than 30 percent.
 - B) Had an occupancy rate greater than 80 percent in the safety net hospital base year.
 - C) Provided greater than 15,000 total days in the safety net hospital base year.
- ~~47~~) The hospital meets all of the following criteria:
- A) Does not already qualify under subsections (a)(1) through (a)~~(3)~~~~(6)~~ of this Section.
 - B) Has an MIUR greater than 25 percent.
 - C) Had an occupancy rate greater than 68 percent in the safety net hospital base year.
 - D) Provided greater than 12,000 total days in the safety net hospital base year.
- ~~8~~) ~~The hospital meets all of the following criteria in the safety net base year:~~
- ~~A) Is a rural hospital, as described in Section 148.25(g)(3).~~
 - ~~B) Has an MIUR greater than 18 percent.~~
 - ~~C) Has a combined MIUR greater than 45 percent.~~

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~~D) Has licensed beds less than or equal to 60.~~

~~E) Provided greater than 400 total days.~~

~~F) Provided fewer than 125 obstetrical care days.~~

~~59)~~ The hospital meets all of the following criteria in the safety net base year:

A) Is a psychiatric hospital, as described in Section 148.25(d)(1), 89 Ill. Adm. Code 149.50(e)(1).

B) Has licensed beds greater than 120.

C) Has an average length of stay less than ten days.

~~10)~~ ~~The hospital meets all of the following criteria in the safety net base year:~~

~~A) Does not already qualify under subsections (a)(1) through (a)(9) of this Section.~~

~~B) Has an MIUR greater than 17 percent.~~

~~C) Has licensed beds greater than 450.~~

~~D) Has an average length of stay less than four days.~~

~~611)~~ The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(~~5~~)(~~10~~) of this Section.

B) Has an MIUR greater than 21 percent.

C) Has licensed beds greater than 350.

D) Has an average length of stay less than 3.15 days.

~~12)~~ ~~The hospital meets all of the following criteria in the safety net base year:~~

~~A) Does not already qualify under subsections (a)(1) through (a)(11) of this Section.~~

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- B) ~~Has an MIUR greater than 34 percent.~~
- C) ~~Has licensed beds greater than 350.~~
- D) ~~Is designated a perinatal Level II center by the Illinois Department of Public Health.~~
- 13) The hospital meets all of the following criteria in the safety net base year:
 - A) ~~Does not already qualify under subsections (a)(1) through (a)(12) of this Section.~~
 - B) ~~Has an MIUR greater than 35 percent.~~
 - C) ~~Has an average length of stay less than four days.~~
- 14) The hospital meets all of the following criteria in the safety net base year:
 - A) Does not already qualify under subsections (a)(1) through (a)(6)(13) of this Section.
 - B) Has a Combined MIUR greater than 25 percent.
 - C) Has an MIUR greater than 12 percent.
 - D) Is designated a perinatal Level II center by the Illinois Department of Public Health.
 - E) Has licensed beds greater than 400.
 - F) Has an average length of stay less than 3.5 days.
- 15) ~~A hospital provider that would otherwise be excluded from payment by subsection (a) because it does not operate a comprehensive emergency room, if the hospital provider operates within 1 mile of an affiliate hospital provider that is owned and controlled by the same governing body that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), and the provider operates a standby emergency room, as defined in 77 Ill. Adm. Code 250.710(e), and functions as an overflow emergency room for its affiliate hospital provider.~~
- 16) ~~The hospital has an MIUR greater than 90% in the safety net hospital base year.~~

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~~817~~) The hospital meets all of the following criteria in the safety net base year:

- A) Does not already qualify under subsections (a)(1) through (a)~~(7)(16)~~ of this Section.
- B) Is located outside Health Service Area (HSA) 6.
- C) Has an MIUR greater than 16%.
- D) Has licensed beds greater than 475.
- E) Has an average length of stay less than five days.

~~918~~) The hospital meets all of the following criteria in the safety net base year:

- A) Provided greater than 5,000 obstetrical care days.
- B) Has a combined MIUR greater than 80%.

~~1019~~) The hospital meets all of the following criteria in the safety net base year:

- A) Does not already qualify under subsections (a)(1) through (a)~~(9)(18)~~ of this Section.
- B) Has a CMIUR greater than 28 percent.
- C) Is designated a perinatal Level II center by the Illinois Department of Public Health.
- D) Has licensed beds greater than 320.
- E) Had an occupancy rate greater than 37 percent in the safety net hospital base year.
- F) Has an average length of stay less than 3.1 days.

~~20~~) ~~The hospital meets all of the following criteria in the safety net base year:~~

- ~~A) Does not already qualify under subsections (a)(1) through (a)(19) of this Section.~~

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- ~~B) Is a general acute care hospital.~~
- ~~C) Is designated a perinatal Level II center by the Illinois Department of Public Health.~~
- ~~D) Provided greater than 1,000 rehabilitation days in the safety net hospital base year.~~
- 21) The hospital meets all of the following criteria in the safety net base year:
 - ~~A) Qualifies as a children's hospital under subsection (c)(1) of this Section.~~
 - ~~B) Has an average length of stay less than 3.25 days.~~
 - ~~C) Provided greater than 1,000 total days in the safety net hospital base year.~~
- b) The following five classes of hospitals are ineligible for safety net adjustment payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4), subsections (a)(6) through (a)(8), subsections (a)(10) through (a)(15) and subsections (a)(17) through (a)(19) of this Section:
 - ~~1) Hospitals located outside of Illinois.~~
 - ~~2) County owned hospitals, as described in Section 148.25(b)(1)(A).~~
 - ~~3) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).~~
 - ~~4) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(e)(1).~~
 - ~~5) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(e)(4).~~
- e) Safety Net Adjustment Rates
 - ~~1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:
 - ~~A) A qualifying hospital—\$15.00.~~~~

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- B) ~~A rehabilitation hospital, as described in 89 Ill. Adm. Code 149.50(e)(2) — \$20.00.~~
- ~~C) A children's hospital, as described in 89 Ill. Adm. Code 149.50(e)(3) — \$20.00.~~
- D) ~~A children's hospital that has an MIUR greater than or equal to 80 per centum that is:
 - i) ~~Located within HSA 6 or HSA 7 — \$296.00.~~
 - ii) ~~Located outside HSA 6 or HSA 7 — \$35.00.~~~~
- E) ~~A children's hospital that has an MIUR less than 80 per centum, but greater than or equal to 60 per centum, that is:
 - i) ~~Located within HSA 6 or HSA 7 — \$35.00.~~
 - ii) ~~Located outside HSA 6 or HSA 7 — \$15.00.~~~~
- F) ~~A children's hospital that has an MIUR less than 60 per centum, but greater than or equal to 45 per centum, that is:
 - i) ~~Located within HSA 6 or HSA 7 — \$12.00.~~
 - ii) ~~Located outside HSA 6 or HSA 7 — \$5.00.~~~~
- G) ~~A children's hospital with more than 25 graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory" — \$160.25.~~
- H) ~~A children's hospital that is a rural hospital — \$145.00.~~
- I) ~~A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital that is located in HSA 6 and that:
 - i) ~~Provides obstetrical care — \$10.00.~~
 - ii) ~~Has at least one graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" — \$5.00.~~~~

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- iii) ~~Has at least one obstetrical graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory"—\$5.00.~~
- iv) ~~Provided more than 5,000 obstetrical days during the safety net hospital base year—\$35.00.~~
- v) ~~Provided fewer than 4,000 obstetrical days during the safety net hospital base year and its average length of stay is: less than or equal to 4.50 days—\$5.00; less than 4.00 days—\$5.00; less than 3.75 days—\$5.00.~~
- vi) ~~Provides obstetrical care and has an MIUR greater than 65 percent—\$11.00.~~
- vii) ~~Has greater than 700 licensed beds—\$37.75.~~

b) ~~For a hospital qualifying under subsection (a)(1) of this Section that is neither a rehabilitation hospital nor a children's hospital, that is located outside HAS 6, that has an MIUR greater than 50 per centum, and that: A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has an MIUR greater than 50 per centum, and that:~~

- 1) ~~Provides obstetrical care — \$210.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~
- 2) ~~Does not provide obstetrical care — \$90.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

- c) ~~For a hospital qualifying under subsection (a)(2) of this Section, the rate shall be \$55.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~
- d) ~~For a hospital qualifying under subsection (a)(3) of this Section, the rate is \$3.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~
- e) ~~For a hospital qualifying under subsection (a)(4) of this Section, the rate is \$140.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~

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- f) For a hospital qualifying under subsection (a)(5) of this Section, the rate is \$47.50 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.
- g) For a hospital qualifying under subsection (a)(6) of this Section, the rate is \$221.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.
- h) For a hospital qualifying under (a)(7) of this Section, the rate is \$100.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.
- i) For a hospital qualifying under subsection (a)(8) of this Section, the rate is \$69.00. The reimbursement rate is contingent on federal approval through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.
- j) For a hospital qualifying under subsection (a)(9) of this Section, the rate is \$56.00 for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is \$136.00. For dates of service on or after July 1, 2014 through December 31, 2014, the rate is \$56.00. For dates of service on or after January 1, 2015, the rate is \$0.00.
- k) For a hospital qualifying under subsection (a)(10) of this Section, the rate is \$84.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.
 - i)- ~~Provides obstetrical care—\$280.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$70.00.~~
 - ii)- ~~Does not provide obstetrical care—\$120.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$30.00.~~
 - iii)- ~~Is a trauma center, recognized by the Illinois Department of Public Health (DPH), as of July 1, 2005—\$173.50.~~
- K)- ~~A qualifying hospital that provided greater than 35,000 total days in the safety net hospital base year—\$43.25.~~
- L)- ~~A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical~~

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~~Education Directory", with an average length of stay fewer than 4.00 days—\$48.00.~~

- 2) ~~For a hospital qualifying under subsection (a)(2) of this Section, the rate shall be \$123.00 for dates of service through March 2, 2013. The rate shall be increased by \$121.00, to \$244.00, for dates of service on or after March 3, 2013 through June 30, 2013. For dates of service on or after July 1, 2013, the rate shall be \$123.00.~~
- 3) ~~For a hospital qualifying under subsection (a)(3) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:~~
 - A) ~~A qualifying hospital—\$40.00.~~
 - B) ~~A hospital that has an average length of stay of fewer than 4.00 days, and:~~
 - i) ~~More than 150 licensed beds—\$20.00.~~
 - ii) ~~Fewer than 150 licensed beds—\$40.00.~~
 - C) ~~A qualifying hospital with the lowest average length of stay—\$15.00.~~
 - D) ~~A hospital that has a CMIUR greater than 65 per centum—\$35.00.~~
 - E) ~~A hospital that has fewer than 25 total admissions in the safety net hospital base year—\$160.00.~~
- 4) ~~For a hospital qualifying under subsection (a)(4) of this Section, the rate shall be \$110.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$55.00.~~
- 5) ~~For a hospital qualifying under subsection (a)(5) of this Section, the rate is the sum of the amounts for each of the following for which it qualifies, divided by the hospital's total days:~~
 - A) ~~The hospital that has the highest number of obstetrical care admissions—\$30,840.00.~~
 - B) ~~The greater of:~~

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- i) ~~The product of \$115.00 multiplied by the number of obstetrical care admissions.~~
- ii) ~~The product of \$11.50 multiplied by the number of general care admissions.~~
- 6) ~~For a hospital qualifying under subsection (a)(6) of this Section, the rate is \$56.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$53.00.~~
- 7) ~~For a hospital qualifying under subsection (a)(7) of this Section, the rate is \$315.50 through December 31, 2014 if federal approval is received by the Department for that rate; otherwise, the rate shall be \$210.50. For dates of service on or after January 1, 2015, the rate is \$210.50.~~
- 8) ~~For a hospital qualifying under subsection (a)(8) of this Section, the rate is \$124.50.~~
- 9) ~~For a hospital qualifying under subsection (a)(9) of this Section, the rate is \$133.00. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by \$72.00, to \$205.00. For dates of service on or after January 1, 2015, the rate is \$85.50.~~
- 10) ~~For a hospital qualifying under subsection (a)(10) of this Section, the rate is \$13.75. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by \$25.00, to \$38.75. For dates of service on or after January 1, 2015, the rate is \$13.75.~~
- 11) ~~For a hospital qualifying under subsection (a)(11) of this Section, the rate is \$421.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$39.50.~~
- 12) ~~For a hospital qualifying under subsection (a)(12) of this Section, the rate is \$240.50 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$120.25.~~
- 13) ~~For a hospital qualifying under subsection (a)(13) of this Section, for dates of service on or after April 1, 2009, the rate is \$815.00.~~
- 14) ~~For a hospital qualifying under subsection (a)(14) of this Section, the rate is \$443.75 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$343.75.~~

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- 15) ~~For a hospital qualifying under subsection (a)(16) of this Section, the rate is \$39.50.~~
- 16) ~~For a hospital qualifying under subsection (a)(17) of this Section, the rate is \$69.00. This reimbursement rate is contingent on federal approval.~~
- 17) ~~For a hospital qualifying under subsection (a)(18) of this Section, the rate is \$56.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$16.00. This reimbursement rate is contingent on federal approval.~~
- 18) ~~For a hospital qualifying under subsection (a)(19) of this Section, the rate is \$229.00. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by \$113.00, to \$342.00. For dates of service on or after January 1, 2015, the rate is \$145.00.~~
- 19) ~~For a hospital qualifying under subsection (a)(20) of this Section, the rate is \$71.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00.~~
- 20) ~~For a hospital qualifying under subsection (a)(21) of this Section, the rate is \$1986.00 for dates of service on or after March 3, 2013 through June 30, 2013. For dates of service on or after July 1, 2013, the rate is \$0.00.~~

ld) Payment to a Qualifying Hospital

- 1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by two multiplied by total days.
- 2) For the safety net adjustment period occurring in State fiscal year 2011, total payments will be determined through application of the methodologies described in subsection (c) of this Section.
- 3) For safety net adjustment periods occurring after State fiscal year 2010, total payments made under this Section shall be paid in installments on, at least, a quarterly basis.

me) Definitions

- 1) "Average length of stay" means, for a given hospital, a fraction in which the numerator is the number of total days and the denominator is the number of total admissions.

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- 2) "CMIUR" means, for a given hospital, the sum of the MIUR plus the Medicaid obstetrical inpatient utilization rate, determined as of October 1, 2001, as defined in Section ~~148.122(g)(3)~~~~148.120(i)(6)~~.
- 3) "General care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department by June 30, 2001, excluding admissions for: obstetrical care, as defined in subsection (e)(7) of this Section; normal newborns; psychiatric care; physical rehabilitation; and those covered in whole or in part by Medicare (Medicaid/Medicare crossover admissions).
- 4) "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.
- 5) "Licensed beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."
- 6) "MIUR", for a given hospital, has the meaning as defined in Section 148.120(i)~~(4)(5)~~ and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for safety net adjustment payments in the Safety Net Adjustment Period.
- 7) "Obstetrical care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data, for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001, and were assigned by the Department a diagnosis related grouping (DRG) code of 370 through 375.
- 8) "Obstetrical care days" means, for a given hospital, days of hospital inpatient service associated with the obstetrical care admissions described in subsection (e)(7) of this Section.

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- 9) "Occupancy rate" means, for a given hospital, a fraction, the numerator of which is the hospital's total days, excluding long term care and substance abuse days, and the denominator of which is the hospital's total beds, excluding long term care and substance abuse beds, multiplied by 365 days. The data used for calculation of the hospital occupancy rate is as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".
- 10) "Safety net hospital base year" means the 12-month period beginning on July 1, 1999, and ending on June 30, 2000.
- 11) "Safety net adjustment period" means, beginning July 1, 2002, the 12 month period beginning on July 1 of a year and ending on June 30 of the following year.
- 12) "Total admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.
- 13) "Total 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 claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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Section 148.140 Hospital Outpatient and Clinic Services

Effective for dates of service on or after July 1, 2014:

a) Fee-For-Service Reimbursement

- 1) Reimbursement for hospital outpatient and clinic services shall be made on a fee-for-service basis, except for:
 - A) ~~Those services that meet the definition of the Ambulatory Procedure Listing (APL) as Services~~ described in subsection (b)(1) of this Section.
 - B) End stage renal disease treatment (ESRDT) services, as described in subsection (c) of this Section.
 - C) ~~Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D).~~
 - CD) Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section.
- 2) Except for the services reimbursed procedures under the EAPG PPS, APL groupings described in subsection (b)(1) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.
- 3) Hospitals are required to bill the Department utilizing specific service codes. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee-for-service. With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

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- A) ~~The reimbursement rates described in subsection (a)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~
- B) ~~The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~
- 4) ~~Payments under Section 148.140(a)(4) shall cease as of June 30, 2014 for Maternal and Child Health Program Clinics, rates, as described in 89 Ill. Adm. Code 140, Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), and Section 148.25(b)(5)(C). Maternal and Child Health Program rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Maternal and Child Health Program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).~~
- 5) ~~Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.~~
- 6) ~~Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.~~
- 7) ~~With the exception of the retrospective adjustment described in subsection (a)(3) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section.~~
- b) EAPG PPS reimbursement. Reimbursement under EAPG PPS, described in subsection (c), shall be all-inclusive for all services provided by the hospital, without regard to the amount charged by a hospital. Except as provided in

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subsection (b)(3), no separate reimbursement will be made for ancillary services or the services of hospital personnel. Ambulatory Procedure Listing (APL) Effective July 1, 2012, the Department will reimburse hospitals for certain hospital outpatient procedures as described in subsection (b)(1) of this Section.

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1) Outpatient hospital services reimbursed through the EAPG PPS shall include:

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A) Surgical services.

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B) Diagnostic and therapeutic services.

C) Emergency department services.

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D) Observation services.

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E) Psychiatric treatment services.

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2) Excluded from reimbursement under the EAPG PPS are outpatient hospital services reimbursed pursuant to 59 Ill. Adm. Code 131, 59 Ill. Adm. Code 132, 77 Ill. Adm. Code 2090, and Section 148.330.

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3) Exceptions to all-inclusive EAPG PPS rate.

A) A hospital may bill separately for: professional services of:

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i) Professional services of a physician who provided direct patient care.

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ii) Chemotherapy services provided in conjunction with radiation therapy services.

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iii) Physical rehabilitation, occupational or speech therapy services provided in conjunction with an APG PPS reimbursed service.

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B) For the purposes of subsection (3)(A), a physician means:

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i) A physician salaried by the hospital. Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists; no separate reimbursement will be allowed for such providers.

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- ii) A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care.
 - iii) A group of physicians with a financial contract to provide emergency department care.
- c) EAPG PPS payment. The reimbursement to hospitals for outpatient services provided during on the same day shall be the product, rounded to the nearest hundredth, of the following:
 - 1) The EAPG weighting factor of the EAPG to which the service was assigned by the EAPG grouper.
 - 2) The EAPG conversion factor, based on the sum of:
 - A) The product, rounded to the nearest hundredth, of:
 - i) the labor-related share;
 - ii) the Medicare IPPS wage index; and
 - iii) the applicable EAPG standardized amount.
 - B) The product, rounded to the nearest hundredth, of:
 - i) non-labor share; and
 - ii) the applicable EAPG standardized amount.
 - 3) The applicable consolidation factor.
 - 4) The applicable packaging factor.
 - 5) The applicable discounting factor.
 - 6) The applicable policy adjustment factors, as defined in subsection (f), for which the service qualifies.
- d) EAPG standardized amount. The standardized amount established by the Department as the basis for EAPG conversion factor differs based on the provider type:

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- 1) County-operated large public hospital EAPG standardized amount. For a large public hospital, as defined in Section 148.25(a)(1), the EAPG standardized amount is determined in Section 148.160.
- 2) University-operated large public hospital EAPG standardized amount. For a large public hospital, as defined in Section 148.25(a)(2), the EAPG standardized amount is determined in Section 148.170.
- 3) Critical access hospital EAPG standardized amount. For critical access hospitals, as defined in Section 148.25(g), the EAPG standardized amounts are determined separately for each critical access hospital such that:
 - A) simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Section 148.456 net of tax costs are equal to:
 - B) estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.
- 4) Acute EAPG standardized amount.
 - A) Qualifying criteria. General acute hospitals excluding providers in subsections (d)(1) through (d)(3) in this Section, freestanding psychiatric hospitals, psychiatric distinct part units, freestanding rehabilitation hospitals, and rehabilitation distinct part units.
 - B) The acute EAPG standardized amount is based on a single statewide amount determined such that:
 - i) Simulated EAPG payments, without SMART Act reductions or policy adjustments defined in subsection (f), using general acute hospital outpatient base period paid claims data, results in approximately a \$75 million increase compared to:
 - ii) The sum of general acute hospital base period paid claims data reported payments and allocated outpatient static payments.
- 5) Psychiatric EAPG standardized amount

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- A) Qualifying criteria. Freestanding psychiatric hospitals and psychiatric distinct part units.
- B) The psychiatric EAPG standardized amount is based on a single statewide amount, determined such that:
 - i) Simulated EAPG payments, without policy adjustments defined in subsection (f), using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data, results in payments approximately equal to:
 - ii) The sum of freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.
- 6) Rehabilitation EAPG standardized amount.
 - A) Qualifying criteria. Freestanding rehabilitation hospitals and rehabilitation distinct part units.
 - B) The rehabilitation EAPG standardized amount is based on a single statewide amount, determined such that:
 - i) Simulated EAPG payments, without SMART Act reductions or policy adjustments defined in subsection (f), using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data, results in payments approximately equal to:
 - ii) The sum of freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.
- 7) Ambulatory Surgical Treatment Center (ASTC) EAPG standardized amount. For ASTC's, as defined in 89 Ill. Adm. Code 146.105, the EAPG standardized amount is determined such that simulated EAPG payments using outpatient base period paid claims data are equal to reported

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payments of outpatient base period paid claims data as contained in the Department's claims data warehouse.

e) Discounting factor. The applicable discounting factor is based on the discounting flags designated by the EAPG grouper under default EAPG settings:

1) The discounting factor will be 1.0000, if the following criteria are met:

A) The service has not been designated with a Bilateral Procedure Discounting flag, Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or

B) The service has not been designated with a Bilateral Procedure Discounting flag and has been designated with a Multiple Procedure Discounting flag by the EAPG grouper under default EAPG settings and the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

2) The discounting factor will be 0.5000 if the following criteria are met:

A) The service has been designated with a Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day; and

B) The service has not been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings.

3) The discounting factor will be 0.7500 if the following criteria are met:

A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B) The service has been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or

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Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

4) The discounting factor will be 1.5000 if the following criteria are met:

A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B) The service has not been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or if the Multiple Procedure Discounting flag is present, the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

f) Policy adjustments. Claims for services by providers that meet certain criteria shall qualify for further adjustments to payment. If a claim qualifies for more than one policy adjustment, then the EAPG PPS payment will be multiplied by both factors.

1) Safety Net hospital. Qualifying criteria

A) The service is described in (b)(1), excluding Medicare crossover claims.

B) The hospital is a Safety Net hospital, as defined in section 5-5e.1 of the Illinois Public Aid Code [305 ILCS 5], that is not:

i) A critical access hospital, as defined in Section 148.25(g).

ii) A large public hospital, as defined in Section 148.25(a).

C) Policy adjustment factor effective State fiscal year 2015 and 2016 is 1.3252.

2) High Outpatient Volume hospital. Qualifying criteria

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- A) The service is described in (b)(1), excluding Medicare crossover claims.
 - B) The hospital is a High Outpatient Volume hospital, as defined in subsection (2)(C) that is not:
 - i) A critical access hospital, as defined in Section 148.25(g).
 - ii) A large public hospital, as defined in Section 148.25(a).
 - iii) A Safety Net hospital, as defined in Section 5-5e.1 of the Illinois Public Aid Code [305 ILCS5].
 - C) A High Outpatient Volume hospital for which the high outpatient volume is at least:
 - i) One-on-one half standard deviations above the mean regional high outpatient volume, or
 - ii) One and one-half standard deviations above the mean statewide high outpatient volume.
 - D) Policy adjustment factor effective State fiscal year 2015 and 2016 is 1.3252.
- 3) Crossover Adjustment Factor
- A) Acute EAPG standardized amounts, as defined in subsection (2)(C), shall be reduced by a Crossover Adjustment factor such that:
 - i) The absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment factor to simulated EAPG payments, including Policy Adjustments, using general acute hospital outpatient base period paid claims data, is equal to:
 - ii) The difference of: total simulated EAPG payments using general acute hospital outpatient crossover paid claims data, and general acute hospital outpatient crossover paid claims data total reported Medicaid net liability.

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- B) Crossover Adjustment Factor effective State fiscal year 2015 and 2016 is 0.98912.
- 4) If a claim does not qualify for a Policy Adjustment described in subsection (f)(1) through (f)(3) of this Section, the policy adjustment factor is 1.0.
- g) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:
- 1) For outpatient services or home dialysis treatments provided pursuant to Sections 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2124 and 413.170 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).
- 2) Payment for non-routine services. For services that are provided during outpatient or home dialysis treatment pursuant to Sections 148.40(c)(2) or (c)(3) but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.50, and 140.75 through 140.481, respectively.
- 3) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.
- Freestanding Emergency Centers
A Freestanding Emergency Center (FEC), as defined in Section 148.25(h) of this Part, is eligible to enroll for reimbursement of emergency services.
Reimbursement for the emergency services provided in an FEC shall be made at the applicable APL group rate identified in subsection (b) of this Section.
Payment for salaried physician services performed in conjunction with an APL procedure shall be made in accordance with subsection (b) of this Section.
- h) Updates to EAPG PPS reimbursement. The Department may annually review the components as listed in subsection (c) of this Section and make adjustments as needed.
- i) Definitions

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“Aggregate ancillary cost-to-charge ratio” means the ratio of each hospital’s total ancillary costs and charges reported in the Medicare cost report, excluding special purpose cost centers and the ambulance cost center, for the cost reporting period matching the outpatient base period claims data. Aggregate ancillary cost-to-charge ratios applied to SFY 2011 outpatient base period claims data will be based on fiscal year ending 2011 Medicare cost report data.

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“Consolidation factor” means a factor of 0 percent applicable for services designated with a Same Procedure Consolidation Flag or Clinical Procedure Consolidation Flag by the EAPG grouper under default EAPG settings.

“Default EAPG settings” means the default EAPG grouper options in 3M’s Core Grouping Software for each EAPG grouper version.

“EAPG” means Enhanced Ambulatory Patient Groups, as defined in the EAPG grouper, which is a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Services provided in each EAPG have similar clinical characteristics and similar resource use and cost.

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“EAPG grouper” means the most recently released version of the Enhanced Ambulatory Patient Group (EAPG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during with the discharge occurred; except, for the calendar year beginning January 1, 2014, EAPG grouper means the version 3.7 of the EAPG software.

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“EAPG PPS” means the EAPG prospective payment system as described in this Section.

“EAPG weighting factor” means, for each EAPG, the product, rounded to the nearest ten-thousandth, of (i) the national weighting factor, as published by 3M Health Information Systems for the EAPG grouper, and (ii) the Illinois experience adjustment.

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“Estimated cost of outpatient base period claims data” means the product of (i) outpatient base period paid claims data total covered charges, (ii) the critical access hospital’s aggregate ancillary cost-to-charge ratio, and (iii) a rate year cost inflation factor.

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“High outpatient volume” means the number paid outpatient services described in Section (b)(1) provided during the high volume outpatient base period paid claims

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data.

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

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“Illinois experience adjustment” means for the calendar year beginning January 1, 2014, a factor of 1.0; for subsequent calendar years, means the factor applied to 3M EAPG national weighting factors when updating EAPG grouper versions determined such that the arithmetic mean EAPG weighting factor under the new EAPG grouper version is equal to the arithmetic mean EAPG weighting factor under the prior EAPG grouper version using outpatient base period claims data.

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

“Mean regional high outpatient volume” means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D) of this Section, provided by hospitals within a region, based on outpatient base period paid claims data.

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“Mean statewide high outpatient volume” means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D) of this Section, provided by hospitals within the state, based on outpatient base period paid claims data.

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“Medicare IPPS wage index” means the wage index used for inpatient reimbursement as described in 89 Ill. Adm. Code 149.100.

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

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“Outpatient base period paid claims data” means State fiscal year 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates

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of service, the most recently available adjudicated 12 months of outpatient paid claims data to be identified by the Department.

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

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“Packaging factor” means a factor of 0 percent applicable for services designated with a Packaging Flag by the EAPG grouper under default EAPG settings plus EAPG 430 (CLASS I CHEMOTHERAPY DRUGS), EAPG 435 (CLASS I PHARMACOTHERAPY), EAPG 495 (MINOR CHEMOTHERAPY DRUGS), EAPG 496 (MINOR PHARMACOTHERAPY), and EAPGs 1001-1020 (DURABLE MEDICAL EQUIPMENT LEVEL 1-20), and non-covered revenue codes defined in the Handbook for Hospital Services.

“Rate year cost inflation factor” means the cost inflation from the midpoint of the outpatient base period paid claims data to the midpoint of the rate year based on changes in Centers for Medicare and Medicaid Services (CMS) input price index levels. For critical access hospital rates effective SFY 2015, the rate year cost inflation factor will be based on changes in CMS input price index levels from the midpoint of SFY 2011 to SFY 2015.

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“Region” means, for a given hospital, the rate region, as defined Section 140. Table J, within which the hospital is located.

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“Total covered charges” means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMS 1450), or one of its electronic transaction equivalents.

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APL Groupings

Under the APL, a list was developed that defines those technical procedures that require the use of the hospital outpatient setting, its technical staff or equipment. These procedures are separated into separate groupings based upon the complexity and historical costs of the procedures. The groupings are as follows:

A) Surgical Groups

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- i) ~~Surgical group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment. The rate for this surgical procedure group shall be \$1,794.00.~~
- ii) ~~Surgical group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate for this surgical procedure group shall be \$1,049.00.~~
- iii) ~~Surgical group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for this surgical procedure group shall be \$752.00.~~
- iv) ~~Surgical group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician administered diagnostic and therapeutic procedures. Certain dental procedures performed by dentists are included in this group. In order for a dental procedure to be eligible for reimbursement in the outpatient setting, the following criteria must be met: patient requires general anesthesia or conscious sedation; patient has a medical condition that places the patient at an increased surgical risk, such as, but not limited to, cardiopulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or the patient cannot be safely managed in an office setting because of behavioral, developmental, or mental disorder. The rate for this surgical procedure group shall be \$287.00.~~

B) ~~Diagnostic and Therapeutic Groups~~

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- i) ~~Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician. The rate for this surgical procedure group shall be \$941.00.~~
- ii) ~~Diagnostic and therapeutic group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study. The rate for this procedure group shall be \$304.00.~~
- iii) ~~Diagnostic and therapeutic group 2(c) consists of other diagnostic tests. Group 2(c) procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate for this procedure group shall be \$176.00.~~
- iv) ~~Diagnostic and therapeutic group 2(d) consists of therapeutic procedures. Group 2(d) procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures. The rate for this procedure group shall be \$136.00.~~
- e) ~~Group 3 reimbursement for services provided in a hospital emergency department will be made in accordance with one of the three levels described in this Section. Emergency Services mean those services that are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the Department shall be based upon the circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.~~

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- i) ~~Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function or requires an intense level of physician or nursing intervention. An "intense level" is defined as more than two hours of documented one on one nursing care or interactive treatment. The rate for this service shall be \$181.00.~~
- ii) ~~Emergency Level II refers to Emergency Services that do not meet the definition in this Section of Emergency Level I care, but that are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity. The rate for this service shall be \$67.00.~~
- iii) ~~Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Level I or II stated in this Section. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided or a screening fee, but not both. The rate for this service shall be \$26.00.~~
- D) ~~Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting that provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories:~~
 - i) ~~for at least 60 minutes but less than six hours and 31 minutes of services, the rate shall be \$74.00;~~
 - ii) ~~for at least six hours and 31 minutes but less than 12 hours and 31 minutes of services, the rate shall be \$222.00; or~~

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- ~~iii) for at least 12 hours and 31 minutes or more of services, the rate shall be \$443.00.~~

- E) ~~Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse, at different rates, Type A and Type B Psychiatric Clinic Services, as defined in Section 148.40(d)(1). A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(e)(3)(A).~~
 - ~~i) The rate for Type A psychiatric clinic services shall be \$68.00.~~
 - ~~ii) The rate for Type A psychiatric clinic services provided by a Children's Hospital shall be \$102.00.~~
 - ~~iii) The rate for Type B psychiatric clinic services shall be \$101.00.~~
 - ~~iv) The rate for Type B psychiatric clinic services provided by a Children's Hospital shall be \$102.00.~~

- F) ~~Effective July 1, 2012, subject to 89 Ill. Adm. Code 152.100, Group 6 for physical rehabilitation services shall no longer be in effect and outpatient physical rehabilitation services provided by a hospital shall be reimbursed through the non-institutional payment system, but will be reimbursed as a hospital service at the following rates of reimbursement:~~
 - ~~i) The rate for rehabilitation services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.~~
 - ~~ii) The rate for rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation shall be \$115.00.~~
 - ~~iii) The rate for rehabilitation services provided by children's hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(3)(A), shall be \$130.00.~~

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- 2) ~~Each of the groups described in subsection (b)(1) of this Section will be reimbursed by the Department considering the following:~~
- A) ~~The Department will provide cost outlier payments for specific devices and drugs associated with specific APL procedures. Such payments will be made if:~~
 - i) ~~The device or drug is on an approved list maintained by the Department. In order to be approved, the Department will consider requests from medical providers and shall base its decision on medical appropriateness of the device or drug and the costs of such device or drug; and~~
 - ii) ~~The provision of such devices or drugs is deemed to be medically appropriate for a specific client, as determined by the Department's physician consultants.~~
 - B) ~~Additional payment for such devices or drugs, as described in subsection (b)(2)(A) of this Section, will require prior authorization by the Department unless it is determined by the Department's professional medical staff that prior authorization is not warranted for a specific device or drug. When such prior authorization has been denied for a specific device or drug, the decision may be appealed as allowed by 89 Ill. Adm. Code 102.80(a)(7) and in accordance with the provisions for assistance appeals at 89 Ill. Adm. Code 104.~~
 - C) ~~The amount of additional payment for devices or drugs, as described in subsection (b)(2)(A) of this Section, will be based on the following methodology:~~
 - i) ~~The product of a cost to charge ratio that, in the case of cost reporting hospitals as described in Section 148.130(d), or in the case of other non-cost reporting providers, equals 0.5 multiplied by the provider's total covered charges on the qualifying claim, less the APL payment rate multiplied by four;~~
 - ii) ~~If the result of subsection (b)(2)(C)(i) of this Section is less than or equal to zero, no additional payment will be made. If the result is greater than zero, the additional payment will equal the result of subsection (b)(2)(C)(i) of this Section;~~

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~~multiplied by 80 percent. In such cases, the provider will receive the sum of the APL payment and the additional payment for such high cost devices or drugs.~~

~~D) For county owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amounts described in subsection (b)(1) of this Section multiplied by a factor of 2.72.~~

~~E) Reimbursement rates for hospitals not required to file an annual cost report with the Department may be lower than those listed in this Section.~~

~~F) Reimbursement for each APL group described in this subsection (b) shall be all inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee for service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital; chemotherapy services provided in conjunction with radiation therapy services; and physical rehabilitation, occupational or speech therapy services provided in conjunction with any APL group described in this subsection (b). For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers. -~~

~~3) The assignment of procedure codes to each of the reimbursement groups in subsections (b)(1)(A) through (b)(1)(E) of this Section are detailed in the Department's Hospital Handbook and in notices to providers.~~

~~4) A one-time fiscal year 2000 payment will be made to hospitals. Payment will be based upon the services, specified in this Section, provided on or after July 1, 1998, and before July 1, 1999, which were submitted to the~~

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~~Department and determined eligible for payment (adjudicated) by the Department on or prior to April 30, 2000, excluding services for Medicare/Medicaid crossover claims and claims that resulted in a zero payment by the Department. A one time amount of:~~

- ~~A) \$27.75 will be paid for each service for procedure code W7183 (Psychiatric clinic Type A for adults).~~
- ~~B) \$24.00 will be paid for each service for APL Group 5 (Psychiatric clinic Type A only) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(e)(3)(A).~~
- ~~C) \$15.00 will be paid for each service for APL Group 6 (Physical rehabilitation services) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(e)(3)(A).~~

~~5) County Facility Outpatient Adjustment~~

- ~~A) Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois county with a population of over three million shall be eligible for a county facility outpatient adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Section and are calculated as follows:
 - ~~i) Beginning with July 1, 1995, hospitals under this subsection shall receive an annual adjustment payment equal to total base year hospital outpatient costs trended forward to the rate year minus total estimated rate year hospital outpatient payments, multiplied by the resulting ratio derived when the value 200 is divided by the quotient of the difference between total base year hospital outpatient costs trended forward to the rate year and total estimated rate year hospital outpatient payments divided by one million.~~
 - ~~ii) The payment calculated under this subsection (b)(5)(A) may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~~~

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- ~~iii) The county facility outpatient adjustment under this subsection shall be made on a quarterly basis.~~
 - ~~B) County Facility Outpatient Adjustment Definition. The definitions of terms used with reference to calculation of the county facility outpatient adjustment are as follows:~~
 - ~~i) "Base Year" means the most recently completed State fiscal year.~~
 - ~~ii) "Rate Year" means the State fiscal year during which the county facility adjustment payments are made.~~
 - ~~iii) "Total Estimated Rate Year Hospital Outpatient Payments" means the Department's total estimated outpatient date of service liability, projected for the upcoming rate year.~~
 - ~~iv) "Total Hospital Outpatient Costs" means the statewide sum of all hospital outpatient costs derived by summing each hospital's outpatient charges derived from actual paid claims data multiplied by the hospital's cost to charge ratio.~~
- ~~6) Critical Access Hospital Rate Adjustment~~

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

 - ~~A) An annual distribution factor shall be calculated as follows:~~
 - ~~i) The numerator shall be \$33 million.~~
 - ~~ii) The denominator shall be the RY 2011 total outpatient cost coverage deficit calculated in accordance with 89 Ill. Adm. Code 148.115, less the RY 2011 Rural Adjustment Outpatient Payments calculated in accordance with 89 Ill. Adm. Code 148.115, plus the annual outpatient supplemental payment calculated in accordance with 89 Ill. Adm. Code 148.456.~~

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- ~~B) Hospital Specific Adjustment Value
For each hospital qualified under this subsection (b)(6) the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in subsection (b)(6)(A)(ii) and the distribution factor calculated in subsection (b)(6)(A):~~
- ~~C) Effective for dates of service on or after July 1, 2012, the final APL Rate Adjustment Values shall be the quotient of:
 - ~~i) The hospital specific adjustment value identified in subsection (b)(6)(B) divided by~~
 - ~~ii) The total outpatient services identified in subsections (b)(1)(A) through (b)(1)(E), excluding services for Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the Department's paid claims database as of December 31, 2010.~~~~
- ~~D) Non State Government Owned Provider Adjustment
Final APL rates for hospitals identified in non State government owned or operated providers in the State's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.304.~~
- ~~E) Applicability
The rates calculated in accordance with subsection (b)(6)(A) shall be effective for dates of service beginning January 1, 2011 and shall be adjusted each State fiscal year beginning July 1, 2011.
 - ~~i) For State fiscal year 2011, the rate year shall begin January 1, 2011 and end June 30, 2011.~~
 - ~~ii) For State fiscal year 2012 and beyond, the rate year shall be for dates of services beginning July 1 through June 30 of the subsequent year.~~
 - ~~iii) For purposes of this adjustment, a children's hospital identified in Section 149.50(c)(3)(B) shall be combined with the corresponding general acute care parent hospital.~~~~

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- ~~iv) Beginning with State fiscal year 2012 and each subsequent State fiscal year thereafter, the adjustment to the FY 2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5.~~
- ~~7) No Year-End Reconciliation~~

~~With the exception of the retrospective rate adjustment described in subsection (b)(9) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).~~
- ~~8) Rate Adjustments~~

~~With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(5) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:~~

 - ~~A) The reimbursement rates described in subsection (b)(5) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~
 - ~~B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~
- ~~9) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.~~
- ~~10) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.~~

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- e) ~~Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:~~
- 1) ~~For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.~~
 - 2) ~~For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2163 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).~~
 - 3) ~~Payment for non-routine services. For services that are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3) but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.~~
 - 4) ~~Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.~~
 - 5) ~~With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:~~
 - A) ~~The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~
 - B) ~~The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

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- 6) ~~With the exception of the retrospective rate adjustment described in subsection (e)(5) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (e).~~
- 7) ~~Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) of this Section shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.~~
- d) ~~Non-Hospital-Based-Clinic Reimbursement~~
 - 1) ~~County-Operated-Outpatient-Facility Reimbursement~~

Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as either a Maternal and Child Health Program managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), or as a Critical Clinic Provider, as described in subsection (e) of this Section, shall be on an all-inclusive per-encounter rate basis as follows:

 - A) ~~Base Rate. The per-encounter base rate shall be calculated as follows:~~
 - i) ~~Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.~~
 - ii) ~~The resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.~~
 - iii) ~~The resulting product, as calculated in subsection (d)(1)(A)(ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section to determine the per-encounter base rate.~~
 - iv) ~~The resulting sum, as calculated in subsection (d)(1)(A)(iii) of this Section, shall be the per-encounter base rate.~~
 - B) ~~Supplemental Rate~~

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- i) ~~The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.~~
- ii) ~~The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.~~
- iii) ~~The quotient derived in subsection (d)(1)(B)(i) of this Section shall be added to the product derived in subsection (d)(1)(B)(ii) of this Section, to determine the per encounter supplemental rate.~~
- iv) ~~The resulting sum, as described in subsection (d)(1)(B)(iii) of this Section, shall be the per encounter supplemental rate.~~

C) **Final Rate**

- i) ~~The per encounter base rate, as described in subsection (d)(1)(A)(iv) of this Section, shall be added to the per encounter supplemental rate, as described in subsection (d)(1)(B)(iv) of this Section, to determine the per encounter final rate.~~
- ii) ~~The resulting sum, as determined in subsection (d)(1)(C)(i) of this Section, shall be the per encounter final rate.~~
- iii) ~~The per encounter final rate, as described in subsection (d)(1)(C)(ii) of this Section, shall be adjusted in accordance with subsection (d)(2) of this Section.~~

2) **Rate Adjustments**

~~Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) of this Section, shall be calculated as follows:~~

- A) ~~The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) and (e)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual~~

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~~Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~C) The final rate described in subsection (d)(1)(C) of this Section shall be no less than \$147.09 per encounter.~~

~~3) County operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year end reconciliation is made to the reimbursement calculated under this subsection (d).~~

~~4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non hospital and hospital providers who bill and receive reimbursement on a fee for service basis.~~

~~e) Critical Clinic Providers~~

~~1) Effective for services provided on or after September 27, 1997, a clinic owned or operated by a county with a population of over three million, that is within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection (e) require that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:~~

~~A) .2700 for reimbursement provided during the facility's cost reporting year ending during 1998;~~

~~B) .2900 for reimbursement provided during the facility's cost reporting year ending during 1999;~~

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- ~~C) 3100 for reimbursement provided during the facility's cost reporting year ending during 2000;~~
- ~~D) 3600 for reimbursement provided during the facility's cost reporting year ending during 2001, and~~
- ~~E) 4200 for reimbursement provided during the facility's cost reporting year ending during 2002.~~

- ~~2) Reimbursement for all services provided by any Critical Clinic Provider shall be on an all-inclusive per-encounter rate that shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.~~
- ~~3) Critical Clinic Providers, as described in this subsection (e), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (e).~~
- ~~4) The reimbursement rates described in this subsection (e) shall be no less than the reimbursement rates in effect on July 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

- ~~f) Critical Clinic Provider Pharmacies
Prescribed drugs, dispensed by a pharmacy that is a Critical Clinic Provider, that are not part of an encounter reimbursable under subsection (e) of this Section shall be reimbursed at the rate described in subsection (e)(2) of this Section.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.150 Public Law 103-66 Requirements

Effective for dates of service on or after July 1, 2014:

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- a) All cost reporting hospitals ~~deemed eligible to receive disproportionate share hospital (DSH) adjustment payments, in accordance with Section 148.120;~~ are required; ~~and non-DSH cost reporting hospitals are encouraged,~~ to annually submit annually, on or before August 15 of the rate year in a form or format specified by the Department, at least the following information separated by inpatient and outpatient (including hospital-based clinic services), to the Department:
- 1) The dollar amount of Illinois Medicaid charges rendered in the base year.
 - 2) The dollar amount of hospital charity care charges rendered in the base year for uninsured patients.
 - 3) The dollar amount of hospital bad debt, less any recoveries, rendered in the base year for uninsured patients.
 - 4) The dollar amount of Illinois total hospital charges for care rendered in the base year.
- b) Definitions
- 1) "Medicaid charges" means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the Social Security Act.
 - 2) "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.
 - 3) "Base year" means the hospital's cost reporting period, utilized in the current rate year disproportionate share determination, and as described in Section ~~148.120(i)(1)~~148.120(k)(1).
 - 4) "Hospital charity care charges" and "hospital bad debt" mean inpatient, outpatient and hospital clinic services provided to individuals without health insurance or other sources of third-party coverage. For purposes of the previous statement in this subsection (b)(4), State or unit of local government payments made to a hospital on behalf of indigent patients ~~(i.e., Transitional Assistance and State Family and Children Assistance) is shall~~ is shall not ~~be~~ considered to be a form of insurance or a source of third-party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included. Charity care charges and bad debt cannot include unpaid co-pays or third party obligations of insured

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patients, contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act (42 USC 291).

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.160 Payment Methodology for County-Owned Large Public Hospitals in an Illinois County with a Population of Over Three Million

Effective for dates of service on or after July 1, 2014:

- a) Inpatient Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(b)(5)(e)(8), county-owned hospitals ~~as defined in Section 148.25(a)(1) an Illinois county with a population greater than three million~~ are excluded from the DRG PPS ~~for reimbursement for inpatient hospital services~~ and are reimbursed ~~on a per diem basis in accordance with this Section.~~

1) Inpatient Per Diem Rate Calculation

County-owned hospital inpatient per diem rates are calculated as follows:

A) Each county-owned hospital's inpatient base year costs, including operating capital and direct medical education costs, shall be calculated using inpatient base period claims data and Medicare cost report data with reporting periods matching the inpatient base period.

B) The inpatient base year costs shall be inflated from the midpoint of the inpatient base period claims data to the midpoint of the time period for which rates are being set (rate period) based on an inflation methodology determined by the Department and approved by Centers for Medicare and Medicaid Services (CMS).

C) Calculate the sum of:

i) The total hospital inflated base year costs, excluding non-Medicare crossover claims, in the inpatient base period claims data; and

ii) Total uncovered Medicare crossover claim cost in the inpatient base period claims data.

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- D) The inpatient per diem rate shall be the quotient of:
 - i) Combined inflated base year cost and uncovered Medicare crossover claim cost, per subsection (a)(1)(C); and
 - ii) Total hospital base year covered days, excluding non-Medicare crossover claims, in the inpatient base period claims data.
- E) The inpatient per diem rates shall be reduced if resulting payments exceed available Department funding or the Center for Medicare and Medicaid Services Upper Payment Limit.

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- 2) Rate Updates
County-owned hospital per diem rates shall be updated on an annual basis using more recent inpatient base period claims data, Medicare cost report data and cost inflation data.

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- 3) New hospitals, for which inpatient base period claims data or Medicare cost reports are not on file, will be reimbursed the per diem rate calculated in subsection (a)(1).

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- 4) Review Procedure
The review procedure shall be in accordance with Section 148.310.

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- b) Outpatient Reimbursement Methodology
Base Year Costs
Large public hospitals, as defined in Section 148.25(a) are included in the EAPG PPS for reimbursement for outpatient hospital services as described in Section 148.140, and are to receive provider-specific EAPG standardized amounts.

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- 1) Outpatient EAPG Standardized Amount Calculation
County-owned hospital outpatient EAPG standardized amounts are calculated as follows:
The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals fiscal years ending between 20 and 31 months prior to the fiscal year for which rates are being set.

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- A) Each county-owned hospital's outpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using outpatient base period claims data and Medicare cost report data with reporting periods matching the outpatient base period.

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- B) The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMS.
 - C) EAPG standardized amounts shall be determined for each county-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data.
 - D) EAPG standardized amounts shall be reduced if resulting payments exceed available HFS funding or the Center for Medicare and Medicaid Services Upper Payment Limit.
- 2) Rate Updates and Adjustments. ~~The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.~~
- A) County-owned hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data and costs inflation data.
 - B) Restructuring Adjustments
Adjustments to outpatient base year costs, as described in subsection (b)(1), will be made to reflect restructuring since filing the base year costs reports. The restructuring must have been mandated to meet State, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Par 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring cost must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available cost reports to determine restructuring costs.
- 3) New hospitals, for which outpatient base period claims data or Medicare cost reports are not on file, will be reimbursed EAPG standardized amount calculated. ~~The hospitals' base year direct medical education costs shall be~~

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~~derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.~~

4) Review Procedure

~~The review procedure shall be in accordance with Section 148.320. The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in subsections (b)(1) through (b)(3) of this Section.~~

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- 5) ~~New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in subsection (b)(4) of this Section and inflated in subsection (d)(1) of this Section.~~

c) Definitions Restructuring Adjustments

~~"Inpatient base period paid claims data" means Medicaid fee-for-service inpatient paid claims data from the State fiscal year ending 24 months prior to the beginning of the rate period.~~

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~~"Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 24 months prior to the beginning of the rate period.~~

~~"Rate period" means the State fiscal year for which the county-owned hospital inpatient and outpatient rates are effective.~~

~~Adjustments to the base year cost per diem, as described in subsection (b)(4) of this Section, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports to determine restructuring costs. If audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance, between the sixteenth and last day of the month, the effective date will be the first day of the second month following the~~

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~~month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year cost per diem, as described in subsection (b)(4), which is subject to the inflation adjustment described in subsection (d) of this Section.~~

d) ~~Inflation Adjustment For Base Year Cost Report Inflation~~

1) ~~The base year cost per diem, as defined in subsection (b)(4) of this Section, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in subsection (b)(1) of this Section by the previous year's operating cost per diem.~~

2) ~~Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.~~

3) ~~Effective July 1, 2003, the rate for hospital inpatient services shall be the rate calculated in accordance with subsections (d)(1) and (2) of this Section that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital-specific federal payment limitations.~~

e) ~~Review Procedure~~

~~The review procedure shall be in accordance with Section 148.310.~~

f) ~~Applicable Inpatient Adjustments~~

1) ~~The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG PPS, as described in subsection (a) of this Section, shall be in accordance with Section 148.120.~~

2) ~~The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals which are exempt from the DRG PPS as described in subsection (a) of this Section are described in this Section.~~

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- A) ~~The payment adjustment shall be \$150 plus \$2 for each one percent that the hospital's Medicaid inpatient utilization rate, as described in Section 148.120(k)(5), exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3), multiplied by 3.75. This payment adjustment is based on a rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.~~
- B) ~~The amount calculated pursuant to subsection (f)(2)(A) of this Section shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:~~
 - i) ~~The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or~~
 - ii) ~~The percentage increase in the statewide average hospital payment rate, as described in Section 148.120(k)(8) over the previous year's statewide average hospital payment rate.~~
- C) ~~The amount calculated pursuant to subsections (f)(2)(A) through (f)(2)(B) of this Section shall be no less than the rate calculated in accordance with Section 148.120(g)(2) in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~
- D) ~~Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~
- E) ~~The amount calculated pursuant to subsection (f)(2) of this Section shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

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- 3) ~~County Provider Adjustment.~~
 - A) ~~Effective July 1, 1995, hospitals reimbursed under this Section shall be eligible to receive a county provider adjustment. The methodology used to determine the add-on payment amount is as follows:~~
 - i) ~~Beginning with July 1, 1995, hospitals under this Section shall receive \$15,500 per Medicaid inpatient admission in the base period.~~
 - ii) ~~The payments calculated under this Section may be adjusted by the Department to ensure compliance with aggregate and hospital-specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments.~~
 - iii) ~~The payments made under this subsection shall be made on a quarterly basis.~~
 - B) ~~County Provider Adjustment Definitions.~~
 - i) ~~"Base Period" means State fiscal year 1994.~~
 - ii) ~~"Medicaid Inpatient Admission" means hospital inpatient admissions provided in the base period, which were subsequently adjudicated by the Department through the last day of June, 1995, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns and Medicare/Medicaid crossover days.~~
- 4) ~~Hospitals reimbursed under this Section shall receive supplemental inpatient payments. Effective with admissions on or after July 1, 1995, supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) of this Section, as adjusted for restructuring, as described in subsection (e) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the sum of the calculated disproportionate share and Medicaid percentage per diem payments as described in Section 148.120 and subsection (f)(2) of this~~

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~~Section, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991 through July 31, 1992. Effective July 1, 1995, the supplemental inpatient payments calculated under this subsection shall be no less than the supplemental inpatient rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. Effective July 1, 2003, the supplemental inpatient payment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. The supplemental inpatient payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

- g) ~~Outlier Adjustments~~
Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.
- h) ~~Trauma Center Adjustments.~~ Trauma center adjustments shall be made in accordance with Section 148.290(e).
- i) ~~Reductions to Total Payments~~
 - 1) ~~Copayments.~~ Copayments are assessed in accordance with Section 148.190.
 - 2) ~~Third Party Payments.~~ The requirements of Section 148.290(f)(2) shall apply.
- j) ~~Prepayment and Utilization Review~~
Prepayment and utilization review requirements shall be in accordance with Section 148.240.
- k) ~~Cost Reporting Requirements~~
Cost reporting requirements shall be in accordance with Section 148.210.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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NOTICE OF PROPOSED AMENDMENTS

Section 148.170 Payment Methodology for University-Owned Large Public Hospitals Organized Under the University of Illinois Hospital Act

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Effective for dates of service on or after July 1, 2014:

a) Inpatient Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(b)(5)(e)(8), a large public hospital, as defined in 148.25(a), is organized under the University of Illinois Hospital Act ~~shall be~~ excluded from the DRG PPS for reimbursement for inpatient hospital services and shall be reimbursed on a per diem basis in accordance with this Section.

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1) Inpatient Per Diem Rate Calculation
University-owned hospital inpatient per diem rates are calculated as follows:

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A) Each University-owned hospital's inpatient base years costs, including operating, capital and direct medical education costs, shall be calculated using inpatient base period claims data and Medicare cost report data with reporting periods matching the inpatient base period.

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B) The inpatient base year costs shall be inflated from the midpoint of the inpatient base period claims data to the midpoint of the time period, for which rates are being set (rate period) based on an inflation methodology determined by the Department and approved by the Center for Medicare and Medicaid Services (CMS).

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C) Calculate the sum of:

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i) The total hospital inflated base year costs, excluding non-Medicare crossover claims, in the inpatient base period claims data; and

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ii) Total uncovered Medicare crossover claim cost in the inpatient base period claims data.

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D) The inpatient per diem rate shall be the quotient of:

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i) Combined inflated base year cost and uncovered Medicare crossover claims cost, per subsection (a)(1)(C), and

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ii) Total hospital base year covered days, excluding non-Medicare crossover claims, in the inpatient base period claims data.

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E) The inpatient per diem rates shall be reduced if resulting payments exceed available Department funding or the Center for Medicare and Medicaid Services Upper Payment Limit.

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2) Rate Updates and Adjustments

University-owned hospital per diem rates shall be updated on an annual basis using more recent inpatient base period claims data, Medicare cost report data and cost inflation data.

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3) New hospitals, for which inpatient base period claims data or Medicare cost reports are not on file, will be reimbursed the per diem rate calculated in subsection (a)(1).

4) Review Procedure

The review procedure shall be in accordance with Section 148.310.

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5) Applicable adjustment for DSH Hospitals

The criteria and methodology for making applicable adjustments to DSH hospitals shall be in accordance with Section 148.120.

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b) Outpatient Reimbursement Methodology-Base Year Costs

Large public hospitals, as defined in 148.25(a), are included in the EAPG PPS for reimbursement for outpatient hospital services as described in Section 148.140, and are to receive a provider-specific EAPG standardized amount.

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1) Outpatient EAPG Standardized Amount Calculation

University-owned hospital outpatient EAPG standardized amount is calculated as follows: Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal year 1992.

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A) Each University-owned hospital's outpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using outpatient base period claims data and Medicare cost report data with reporting periods matching the outpatient base period.

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- B) The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMS.
- C) EAPG standardized amounts shall be determined for each state-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data.
- D) EAPG standardized amounts shall be reduced if resulting payments exceed available Department funding or the Centers for Medicare and Medicaid Services Upper Payment Limit.

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- 2) Rate Updates and Adjustments
State-owned hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data and cost inflation data.
For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

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- 3) Review Procedure
The review procedure shall be in accordance with Section 148.310.

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- c) Definitions Restructuring Adjustment

"Inpatient base period paid claims data" means Medicaid fee-for-service inpatient paid claims data from the State fiscal year ending 24 months prior to the beginning of the rate period.

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"Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 24 months prior to the beginning of the rate period.

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“Rate period” means the State fiscal year for which the University-owned hospital inpatient and outpatient rates are effective.

~~Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.~~

- d) ~~Inflation Adjustment For Base Year Cost Report Inflation~~
~~Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.~~
- e) ~~Review Procedure~~
~~The review procedure shall be in accordance with Section 148.310.~~
- f) ~~Applicable adjustments for DSH Hospitals~~
 - 1) ~~The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG-PPS as described in subsection (a) of this Section, shall be in accordance with Section 148.120.~~
 - 2) ~~Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section~~

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~~shall have supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) of this Section, as adjusted for restructuring, as described in subsection (c) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the calculated disproportionate share per diem payment adjustment, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 4.50 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

- g) ~~Outlier Adjustments~~
~~Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.~~
- h) ~~Reductions to Total Payments~~
 - 1) ~~Copayments. Copayments are assessed in accordance with Section 148.190.~~
 - 2) ~~Third Party Payments. The requirements of Section 148.290(f)(2) shall apply.~~
- i) ~~Prepayment and Utilization Review~~
~~Prepayment and utilization review requirements shall be in accordance with Section 148.240.~~
- j) ~~Cost Reporting Requirements~~
~~Cost reporting requirements shall be in accordance with Section 148.210.~~
- k) ~~Rate Period~~
~~The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of July 1, 1995, through September 30, 1995.~~

(Source: Amended at 28 Ill. Reg. _____, effective _____)

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Section 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act (Repealed)

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- a) ~~The Department shall make supplemental disproportionate share (DSH) payments in accordance with this Section to hospitals that meet all of the following requirements:~~
 - 1) ~~Qualify for DSH payment adjustments in accordance with Section 148.120(a).~~
 - 2) ~~Are organized under the Town Hospital Act [60 ILCS 170].~~
 - 3) ~~Have entered into an agreement, approved by the Director.~~
- b) ~~Review Procedure~~

~~The review procedure shall be in accordance with Section 148.310.~~
- e) ~~Applicable Adjustments for Disproportionate Share Hospitals (DSH)~~
 - 1) ~~The criteria and methodology for making applicable adjustments to government owned DSH hospitals as described in subsection (a) above, shall be in accordance with Section 148.120.~~
 - 2) ~~Effective with dates of service on or after May 12, 1995, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall be eligible for supplemental DSH payments. Effective with admissions on or after May 12, 1995, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's alternate cost per diem rate in effect on May 12, 1995, as described in Sections 148.260, 148.270, and 89 Ill. Adm. Code 152.200, and the calculated disproportionate share per diem payment adjustment in effect on May 12, 1995, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payor for the period of August 1, 1991 through July 31, 1992. The resulting product shall be multiplied by 6.25 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided. The supplemental DSH payments cannot exceed the amount the hospital certifies as costs eligible for Federal Financial Participation under Title XIX of the Social Security Act.~~

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~~3) DSH adjustments made under this subsection are subject to the DSH adjustment limitations described in Section 148.120(j).~~

d) ~~Rate Period~~

~~The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of May 12, 1995 through September 30, 1995.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.180 Payment for Pre-operative Days, and Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting

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Effective for dates of service on or after July 1, 2014:

a) Pre-operative Days. For hospitals and distinct part units reimbursed on a per diem basis under Sections ~~148.105, 148.110, 148.116, 148.160 or 148.170~~ ~~148.160, 148.170 or 148.250 through 148.300~~, payment for pre-operative days shall be limited to the day immediately preceding surgery unless the attending physician has documented the medical necessity of an additional day or days. The documentation must be kept in the patient's medical record and must consist of a written notation made by the physician which documents that more than one pre-operative day is medically necessary.

b) ~~Inpatient Procedures Requiring Justification~~

~~1) A list of restricted inpatient procedures has been established. These restricted inpatient procedures will only be reimbursed when performed outside the inpatient setting or when the hospital supplies justification for an inpatient admission that meets Departmental established criteria. These criteria include, but are not limited to:~~

~~A) Presence of medical conditions which make prolonged post-operative observations by a nurse or skilled medical personnel a necessity (e.g., heart disease, severe diabetes);~~

~~B) The patient is in the hospital as an inpatient for a medically necessary condition unrelated to the surgical procedure;~~

~~C) An unrelated procedure is being done simultaneously which itself requires surgical hospitalization;~~

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- D) ~~The practitioner has documented the medical necessity of performing the patient's surgery in an inpatient setting;~~
- E) ~~The patient is unable to comprehend and/or follow the necessary instruction both prior to and following the procedure due to mental and/or physical impairment, and this would result in inadequate treatment and place the patient at risk;~~
- F) ~~Emergency admission or recent onset of severe symptoms would prohibit safely performing the procedure on an outpatient basis (e.g., bleeding, severe pain, nausea, vomiting); and~~
- G) ~~Admission occurs subsequent to the performance of the procedure on an outpatient basis due to conditions such as:~~
 - i) ~~Instability of vital signs;~~
 - ii) ~~Respiratory distress greater than existed pre-operatively;~~
 - iii) ~~Post-operative pain not relieved by oral medication;~~
 - iv) ~~Uncontrollable bleeding;~~
 - v) ~~Lack of state of consciousness appropriate to age and development;~~
 - vi) ~~Presence of persistent nausea or vomiting; and~~
 - vii) ~~Inability to ambulate consistent with age, previous mobility status and/or procedure.~~
- 2) ~~The list of procedures identified as restricted inpatient procedures which may be safely performed outside the inpatient setting and do not require an inpatient admission are reevaluated periodically.~~
- 3) ~~Additions to and deletions from the list of designated restricted inpatient procedures will be made following notice to and consultations with the Department's professional advisory committees, State Medicaid Advisory Committee, representatives selected by the hospitals, other third party payors, the Illinois Hospital Association, and other interested groups or individuals.~~

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be) Ancillary Services and Tests

- 1) Ancillary services and routine tests (those services other than routine room and board and nursing which are required because of the patient's medical condition, including lab tests and x-rays) shall not be covered unless there is a patient specific written order for the test from the attending or operating physician responsible for the care and treatment of the patient. The attending or operating physician responsible for the care and treatment of the patient is required to sign all applicable sections for each test ordered in the appropriate place in the medical record. The order must be legible and explain completely all services or tests to be performed. Standing orders are not acceptable.
- 2) Upon completion of the service or test, a fully documented description of results with findings, or the administration of medication, must be maintained in the patient medical records. Radiological services must have the actual x-rays and the interpretation report; laboratory/pathological tests must have the specific findings for each test; and drugs and pharmaceutical supplies must indicate strength, dosages and durations.
- 3) Charges for any and all such services or tests cannot exceed those charged to the general public. The failure to maintain and provide records as described in this Section shall result in the disallowance of the applicable charges upon audit.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.200 Alternate Reimbursement Systems (Repealed)

- a) ~~Section 148.210 discusses cost reporting requirements for all hospitals participating in the Medicaid Program.~~
- b) ~~Section 148.220 describes the payment methodology for hospital inpatient services to recipients for admissions occurring prior to September 1, 1991.~~
- e) ~~The payments described in Sections 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to the provisions of Section 148.20(b).~~
- d) ~~The payments described in Section 148.82 shall be effective for admissions on and after September 1, 1991, with the exception of provisions that relate to pancreas or kidney pancreas transplants. Provisions relating to pancreas or~~

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~~kidney-pancreas transplants shall be effective for admissions on and after July 1, 1992.~~

- e) ~~Sections 148.250 through 148.300 describe the payment methodologies for hospital inpatient services to recipients of Medical Assistance provided by a hospital not reimbursed under the DRG Prospective Payment System (PPS) described in 89 Ill. Adm. Code Part 149 or the reimbursement methodologies described in Sections 148.82, 148.160 and 148.170.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.210 Filing Cost Reports

Effective for dates of service on or after July 1, 2014:

- a) ~~Excepting those operated by an agency of the United States government, all all hospitals in Illinois and those hospitals in contiguous states providing 100 or more paid acute inpatient days of care to Illinois Medicaid Program participants, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)), shall be required to file Medicaid and Medicare cost reports within 150 days after the close of that provider's fiscal year. Any hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program and census logs by program and financial class. The Bureau of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate analysis.~~
- 1) ~~Any hospital certified in the Medicare Program (Title XVIII) and electing, for the first time, to be reimbursed under the DRG PPS must include a copy of the two most recently audited Medicare cost reports at the time of enrollment.~~
- 2) ~~Any hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program, and census logs by program and financial class. The Office of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate~~

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~~analysis. Should the hospital elect not to comply with the audit request, or the financial statements are given other than an unqualified opinion, the hospital will receive an alternate rate as described in Section 148.270.~~

- b) No extension of the Medicaid cost report due date will be granted by the Department unless the Centers for Medicare and Medicaid Services (CMS) grants an extension of the due date for the related Medicare cost report. Should CMS extend the Medicare cost report due date, the Department will extend the Medicaid and Medicare cost reports due date by an equivalent period of time.
- c) If the hospital has not filed the required Medicaid cost reports within 150 days after the close of the hospital's fiscal year, the Department shall suspend payment for covered medical services until the Department receives the required information.
- d) The assessment or license fees described in 89 Ill. Adm. Code 140, Subpart C, 140.82, 140.84, 140.94 and 140.95 may not be reported as allowable Medicaid costs on the Medicaid cost report.

e) Cost Report Reviews

The Bureau of Health Finance shall audit the information shown on the cost reports. 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.

- f) Hospitals described in Sections 148.25(a)(1) and 148.25(a)(2) shall be required to submit outpatient cost reports to the Department within 150 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.220 Pre September 1, 1991, Admissions **(Repealed)**

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~~Reimbursement to hospitals for claims for admissions occurring prior to September 1, 1991 will be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.230 Admissions Occurring on or after September 1, 1991 (Repealed)

~~Reimbursement to hospitals not reimbursed under the DRG PPS (see 89 Ill. Adm. Code 149) or the reimbursement methodologies established at Sections 148.82, 148.160 and 148.170 for inpatient admissions occurring on or after September 1, 1991 shall be calculated in accordance with Sections 148.250 through 148.300, subject to the provisions of Section 148.20(b).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements

Effective for dates of service on or after July 1, 2014:

a) Utilization Review

The Department, or its designated peer review organization, shall conduct utilization review in compliance with Section 1152 of the Social Security Act and 42 CFR Subchapter F (October 1, ~~2013~~²⁰⁰⁴). A peer review shall be conducted by a Physician Peer Reviewer who is licensed to practice medicine in all its branches, engaged in the active practice of medicine, board certified or board eligible in his or her specialty and has admitting privileges in one or more Illinois hospitals. Payment will only be made for those admissions and days approved by the Department or its designated peer review organization. Utilization review may consist of, but not be limited to, preadmission, concurrent, prepayment, and postpayment reviews to determine, pursuant to 42 CFR 476, Subpart C (October 1, ~~2013~~²⁰⁰⁴), the following:

- 1) Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;
- 2) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges, including, but not limited to, the coordination of care requirements defined in Section 148.40(a)(10) for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program;

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- 3) Through DRG (~~Diagnosis Related Grouping~~) (see 89 Ill. Adm. Code 149) validation, the validity of diagnostic and procedural information supplied by the hospital;
 - 4) The completeness, adequacy and quality of hospital care provided;
 - 5) Whether the quality of the services meets professionally recognized standards of health care; or
 - 6) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type.
- b) Notice of Utilization Review
- The Department shall provide hospitals with notice 30 days before a service is subject to utilization review, as described in subsections (c), (d), (e) and (f) of this Section, that the service is subject to such review. In determining whether a particular service is subject to utilization review, the Department may consider factors that include:
- 1) Assessment of appropriate level of care;
 - 2) The service could be furnished more economically on an outpatient basis;
 - 3) The inpatient hospital stays for the service deviate from the norm for inpatient stays using accepted length of stay criteria;
 - 4) The cost of care for the service;
 - 5) Denial rates; and
 - 6) Trends or patterns that indicate potential for abuse.
- c) Preadmission Review
- Preadmission review may be conducted prior to admission to a hospital to determine if the services are appropriate for an inpatient setting. The Department shall provide hospitals with notice of the criteria used to determine medical necessity in preadmission reviews 30 days before a service is subject to preadmission review.
- d) Concurrent Review

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Concurrent review consists of a certification of admission and, if applicable, a continued stay review.

- 1) The certification of admission is performed to determine the medical necessity of the admission and to assign an initial length of stay based on the criteria for the admission. Admissions will be denied for patients ~~age~~ 21 years of age or over who present at a hospital within 60 days after a previous admission for specified alcohol-induced or drug-induced detoxification. The Department will specify to hospitals the lists of affected diagnosis codes via provider releases and postings on the Department's website.
 - 2) The continued stay review is conducted to determine the medical necessity and appropriateness of continuing the inpatient hospitalization. More than one continued stay review can be performed in an inpatient stay.
- e) Pre-payment Review
The Department may require hospitals to submit claims to the Department for pre-payment review and approval prior to rendering payment for services provided.
- f) Post-payment Review
Post-payment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct post-payment review on specific types of care.
- g) Hospital Utilization Control
Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (~~Title XVIII~~) must meet the utilization review plan requirements in 42 CFR 456.42 CFR, Ch. IV, Part 456 (October 1, ~~2013~~2001). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 148.25(d)(1)~~149.50(e)(1)~~ shall be in accordance with the federal regulations.
- h) Denial of Payment as a Result of Utilization Review
- 1) If the Department determines, as a result of utilization review, that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary

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transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

- A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission, transfer of an individual or failure to comply with the coordination of care requirements of Section 148.40.
 - B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.
- 2) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization, under subsection (h)(1)(A) of this Section as a result of prepayment review, a reconsideration will be provided within 30 days upon the request of a hospital or physician if such request is the result of a medical necessity or appropriateness of care denial determination and is received within 60 days after receipt of the notice of denial. The date of the notice of denial is counted as day one.
- 3) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization under subsection (h)(1)(A) of this Section as a result of a preadmission or concurrent review, the hospital or physician may request an expedited reconsideration. The request for expedited reconsideration must include all the information, including the medical record, needed for the Department or its designated peer review organization to make its determination. A determination on an expedited reconsideration request shall be completed within one business day after the Department's or its designated peer review organization's receipt of the request. Failure of the hospital or physician to submit all needed information shall toll the time in which the reconsideration shall be completed. The results of the expedited reconsideration shall be communicated to the hospital by telephone within one business day and in writing within three business days after the determination.
- 4) A determination under subsection (h)(1) of this Section, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:

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- A) ~~W~~ithholding Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
 - B) ~~T~~ermination of the hospital's Provider Agreement.
- i) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements
- 1) The applicable payments made under this Part and 89 Ill. Adm. Code 149 Sections 148.82, 148.120, 148.130, 148.150, 148.160, 148.170, 148.175 and 148.250 through 148.300 are payment in full for all inpatient hospital services other than for the services of non-hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (i)(1)(B)(i) through (i)(1)(B)(v) of this Section .
 - A) Hospital-based physicians who may not bill separately on a fee-for-service basis:
 - i) A physician whose salary is included in the hospital's cost report for direct patient ~~care may not bill separately on a fee for service basis.~~
 - ii) A teaching physician who provides direct patient care ~~may not bill separately on a fee for service basis~~ if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.
 - B) Hospital-based physicians who may bill separately on a fee-for-service basis:
 - i) A physician whose salary is not included in the hospital's cost report for direct patient care ~~may bill separately on a fee for service basis.~~
 - ii) A teaching physician who provides direct patient care ~~may bill separately on a fee for service basis~~ if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.
 - iii) A resident ~~may bill separately on a fee for service basis~~ when, by the terms of his or her contract with the hospital,

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he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

- iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, ~~may bill separately on a fee-for-service basis~~ when, by the terms of his or her contract with the hospital, he or she may charge for professional services and ~~does~~, in fact, bill private patients and collect and retain the payments received.
- v) A physician holding a nonteaching administrative or staff position in a hospital or medical school ~~may bill separately on a fee-for-service basis to~~ the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

- 2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

- j) "Designated peer review organization" means an organization designated by the Department that is experienced in utilization review and quality assurance, which meets the guidelines in Section 1152 of the Social Security Act and 42 CFR 475 ~~(2013 October 1, 2001)~~.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
(Repealed)

~~The exempt hospitals, defined in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), (c)(4) and (c)(7), shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:~~

- ~~a) allowable operating cost per diem;~~
- ~~b) capital costs reimbursed on a per diem basis;~~

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- e) ~~applicable DSH adjustments as described in Section 148.120 and outlier adjustments as described in Section 148.130; and~~
- d) ~~applicable trauma center adjustments, as described in Section 148.290(c), and Medicaid high volume adjustments, as described in Section 148.290(d).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.260 Calculation and Definitions of Inpatient Per Diem Rates (Repealed)

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- a) ~~Calculation for the first rate year period~~
 - 1) ~~Allowable operating cost per diem~~
 - A) ~~The allowable operating cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units described in Section 148.270(a) and (b), shall be calculated by taking the hospital's Medicaid inpatient operating costs for the base period defined in Section 148.25(g)(1) divided by the hospital's Medicaid inpatient days.~~
 - B) ~~Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:~~
 - i) ~~Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in subsection (a)(1)(A) above.~~
 - ii) ~~Each of the two costs per diem shall be trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~
 - iii) ~~These two trended operating costs per diem are then added together and divided by two.~~
 - iv) ~~The average operating cost per diem calculated in subsection (a)(1)(B)(iii) above is then divided by the indirect medical education (IME) factor, determined by the Health Care Financing Administration (HCFA), in effect ninety days prior to the admission in order to calculate the~~

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~~hospitals final operating cost per diem for the base period. For other hospitals for which an indirect medical education factor is not available, the Department shall calculate an indirect medical education factor using the hospital's most recently available cost report and the Medicare formula in effect 90 days prior to the date of admission.~~

- 2) ~~Capital Related Costs. The capital related cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking the hospital's total capital related costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~
 - A) ~~These two trended capital related costs per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.~~
 - B) ~~The adjusted capital related cost per diem, as calculated in subsection (a)(2)(A) above, shall be rank ordered for all hospitals and capped at the 80th percentile.~~
 - C) ~~Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (a)(2)(A) or subsection (a)(2)(B) above, whichever is less.~~
- 3) ~~Direct Medical Education Costs. The direct medical education cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking total inpatient direct medical education costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~
 - A) ~~The two trended direct medical education costs per diem are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.~~
 - B) ~~The adjusted direct medical education cost per diem, as calculated in subsection (a)(3)(A) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.~~

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~~c) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (a)(3)(A) or subsection (a)(3)(B) above, whichever is less.~~

b) ~~Calculation for Subsequent Rate Periods~~

~~1) For the rate period described in Section 148.25(g)(2)(A), the final rate per diem shall be determined by taking the operating, capital and direct medical education trended rate costs per diems calculated under subsection (a) of this Section and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(A).~~

~~2) For rate periods beginning on or after April 1, 1994, as described in Section 148.25(g)(2)(B), the final rate per diem shall be determined by:~~

~~A) Adding the operating and capital trended rate cost per diems calculated under subsection (a) of this Section that were in effect on June 30, 1993;~~

~~B) Updating the trended rate cost per diems described in subsection (b)(2)(A) above;~~

~~i) In the case of a hospital described in 89 Ill. Adm. Code 149.125(b), by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(B); and~~

~~ii) In the case of a hospital described in 89 Ill. Adm. Code 149.50(e)(1), (e)(2), or (e)(4), or for a hospital unit described in 89 Ill. Adm. Code 149.50(d)(1) or (d)(2), to the midpoint of the current rate period described in Section 148.25(g)(2)(B) by utilizing the TEFRA price inflation factor.~~

e) ~~Rebasing~~

~~For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using the methodology set forth in subsection (a) of this Section for the calculation of operating and capital trended rate cost per diems using base period cost reports, as described in Section 148.25(g)(1).~~

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(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals (Repealed)

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- a) ~~Calculation of Alternate Cost Per Diem Rates for All Hospitals~~
~~For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section 148.260, derived from the provider's base period cost reports, as described in Section 148.25(g)(1).~~
- b) ~~Calculation of Payment Rates for Certain Exempt Hospital Units~~
 - 1) ~~For admissions occurring within the rate period described in Section 148.25(g)(2)(A):~~
 - A) ~~In the case of a distinct part unit, as described in 89 Ill. Adm. Code 149.50(d), the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period.~~
 - B) ~~The resulting quotient, as calculated in subsection (b)(1)(A), shall be multiplied by the hospital's total operating cost per diem, as calculated in Section 148.260(a)(1)(B).~~
 - C) ~~The capital related cost per diem, as calculated in Section 148.260(a)(2), is then added to the resulting product calculated in subsection (b)(1)(B), subject to the inflation adjustment described in Section 148.260(e)(1).~~
 - D) ~~Subject to the provisions of subsections (b)(1)(E) and (b)(1)(F), the final distinct part unit payment rate shall be the lower of:~~
 - i) ~~The result of the calculations described in subsections (b)(1)(A) through (b)(1)(B); or~~
 - ii) ~~The hospital's alternate cost per diem rate, as calculated in subsection (a) of this Section.~~

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- ~~E) In no case shall the hospital's final distinct part unit payment rate be greater than three standard deviations above the mean distinct part unit payment rate.~~
- ~~F) In the case of a new distinct part unit for which the Department has insufficient adjudicated claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b)(1) for like distinct part units.~~
- ~~2) For admissions occurring within a rate period described in Section 148.25(g)(2)(B), the distinct part unit payment rate shall be the distinct part unit payment rate in effect on June 30, 1993, as calculated under subsection (b)(1), updated to the midpoint of the current rate period, using the TEFRA price inflation factor.~~
- e) In the case of a new hospital (not previously owned or operated), a hospital that has significantly changed its case mix profile (e.g., a general acute care hospital changing its case mix to reflect a predominance of long term care patients), or an out-of-state non-cost reporting hospital, reimbursement for inpatient services shall be as follows:
 - ~~1) For general acute care hospitals, reimbursement for inpatient services:
 - A) provided by Illinois general acute care hospitals prior to July 1, 2007 shall be at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.
 - B) provided by Illinois general acute care hospitals on or after July 1, 2007 shall be reimbursed at either of the following:
 - i) utilizing the payment methodologies described in 89 Ill. Adm. Code 149 that will only reflect the federal/regional blended rate described in 89 Ill. Adm. Code 149.100 and a capital rate equal to one standard deviation above the mean capital rate, as determined in 89 Ill. Adm. Code 149.150(e), for all providers reimbursed under the same federal/regional blended rate; or
 - ii) at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~

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- ~~C) provided by out of state general acute care hospitals shall be at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~
- 2) ~~For psychiatric hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(1):~~
 - ~~A) for services provided by a psychiatric hospital that began operation on or after January 1, 2008, that is devoted exclusively to the care of individuals who have not attained 19 years of age, reimbursement for inpatient psychiatric services shall be at the arithmetic mean of the rates defined in subsections (e)(2)(B) and (e)(5)(A) of this Section.~~
 - ~~B) for all other psychiatric hospitals, reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(e)(1).~~
- 3) ~~For rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(2), reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(e)(2).~~
- 4) ~~For long term stay hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(4), reimbursement for inpatient services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(e)(4).~~
- 5) ~~For children's hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(3), reimbursement for inpatient services:~~
 - ~~A) provided before August 1, 1998, shall be at the average rate calculated under subsection (a) for those hospitals defined in 89 Ill. Adm. Code 149.50(e)(3);~~
 - ~~B) provided on or after August 1, 1998, for a children's hospital that was licensed as such by a municipality after June 30, 1995, shall be equal to the average rate calculated in Section 148.280 for children's hospitals in existence before June 30, 1995, with an average length of stay that was less than 14 days as determined~~

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~~from the hospital's fiscal year 1994 cost report.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Repealed)

~~a) Children's Hospitals~~

~~1) Initial Rate Period~~

- ~~A) For purposes of reimbursement, all children's hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(3), are grouped into one peer group.~~
- ~~B) Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.~~
- ~~C) These base period costs shall be updated, trended forward from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set, according to the methodology of the national total hospital market basket price proxies, (DRI).~~
- ~~D) The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.~~

~~2) Subsequent Rate Periods~~

~~For the rate period beginning on October 1, 1992, as described in Section 148.25(g)(1)(A), and for subsequent rate periods, as described in Section 148.25(g)(1)(B), the initial rate, as calculated under subsection (a)(1) above, shall be updated from the midpoint of the base cost reporting~~

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~~period to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~

- b) ~~Hospitals Reimbursed Under Special Arrangements~~
~~Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in Sections 148.40(e) through 148.40(g).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.290 Adjustments and Reductions to Total Payments

Effective for dates of service on or after July 1, 2014:

- a) ~~The adjustments described in this Section, as applicable, shall be made to reimbursement amounts calculated pursuant to Sections 148.105, 148.110, 148.115, 148.140, 148.160, 148.170, 148.330 and 89 Ill. Adm. Code 149.100 prior to payment. The adjustments are to be applied in the order in which they are listed in this Section. Applicable Adjustments for DSH The criteria and methodology for making applicable DSH adjustments to hospitals shall be in accordance with Section 148.120.~~
- b) ~~Adjustments to base rates made pursuant to 89 Ill. Adm. Code 152.150. Outlier Adjustments~~
~~Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130 for hospitals that are exempt from the DRG PPS (see 89 Ill. Adm. Code 149).~~
- c) ~~Increases in payments. Supplemental payments pursuant to the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155] in accordance with Section 148.115(f). County Trauma Center Adjustment (TCA). Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:~~
- 1) ~~The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in subsection (c)(4) of this Section) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The~~

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~~result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.~~

- 2) ~~The county trauma center adjustment payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Public Aid Code.~~
- 3) ~~The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.~~
- 4) ~~Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this subsection shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or a Level II trauma center as required for the adjustment described in subsection (c) of this Section. In these instances, the adjustments calculated under this subsection shall be pro-rated, as applicable, based upon the date that such recognition ceased.~~
- 5) ~~Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by subsection (c) of this Section are as follows:~~
 - A) ~~"Available funds" means funds which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.~~
 - B) ~~"Medicaid trauma admission" means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceeding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through~~

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~~864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under 18 years of age.~~

~~C) "TCA base period" means State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period, State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.~~

~~D) "TCA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~

~~E) "Trauma Center Fund" means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds received by the Department as a result of expenditures made by the Department as required by subsection (c)(4) of this Section.~~

d) Reductions in payments. The Department's payment obligation shall be reduced by Medicaid High Volume Adjustments (MHVA)

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1) Charges. Except for reimbursement calculated under Sections 148.140, 148.160, and 148.170, payment shall not exceed the lesser of: For inpatient admissions occurring on or after October 1, 2003, the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that meet the following criteria:

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- A) ~~The reimbursement amount determined pursuant subsections (a) and (b). Be eligible to receive the adjustment payments described in Section 148.122 in the MHVA rate period; and~~
- B) ~~The allowable charges billed to the Department on the claim. Not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B) in the MHVA rate period.~~
- 2) Hospital rate reductions. Payment shall be reduced pursuant to the provisions of 89 Ill. Adm. Code 152.100. Calculation of Medicaid High Volume Adjustments
 - A) ~~Hospitals meeting the criteria specified in subsection (d)(1) of this Section shall receive a MHVA payment adjustment of \$60.~~
 - B) ~~For children's hospitals, as defined in Section 148.122 (a)(5), the payment adjustment calculated under subsection (d)(2)(A) of this Section shall be multiplied by 2.0.~~
 - C) ~~The amount calculated pursuant to subsections (d)(2)(A) and (d)(2)(B) of this Section shall be adjusted by the aggregate annual increase in the national hospital market price proxies (DRI) hospital cost index (Health Care Cost Review, published by Global Insight, 24 Hartwell Avenue, Lexington MA (2003). This incorporation by reference includes no later amendments or editions.) from the MHVA rate period 1993, as defined in Section 148.290(d)(4)(B), through the MHVA rate period 2003, and annually thereafter, by a percentage equal to the lesser of:
 - i) ~~The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or~~
 - ii) ~~The percentage increase in the statewide average hospital payment rate, as described in subsection (d)(4)(C) of this Section, over the previous year's statewide average hospital payment rate.~~~~

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~~D) The adjustments calculated under subsections (d)(2)(A) through (d)(2)(C) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

- 3) Third-part liability. Hospitals shall determine whether services are covered, in whole or in part, under any program or under any other private group indemnification or insurance program, or managed care entity. To the extent that such coverage is available, the Department's payment obligation shall be reduced. Medicaid High Volume Adjustment Limitations.

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~~Hospitals that qualify for MHVA adjustments under subsections (d)(2)(A) through (d)(2)(C) of this Section shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a Medicaid Percentage Adjustment hospital, as required by subsection (d)(1) of this Section. In this instance, the annual adjustment described in subsections (d)(2)(A) through (d)(2)(C) of this Section shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for Medicaid percentage adjustment payments, under Section 148.122, by the Department.~~

- 4) Copayments. Copayments are assessed in accordance with Section 148.190. Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by subsection (d) of this Section are as follows:

A) "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.

B) "MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

C) "Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

- e) Increases in payments. The Department's payments obligations shall be increased, if applicable, by:

1) Medicaid high volume adjustment payments pursuant to Section 148.112.

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- 2) Medicaid percentage adjustment payments pursuant to Section 148.122.
- 3) Disproportionate share hospital adjustment payments pursuant to Section 148.120.

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~~Inpatient Payment Adjustments based upon Reviews. Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in this Section, or their payment adjustment amounts, in accordance with Section 148.310, which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of this Section.~~

f) ~~Reductions to Total Payments~~

- 1) ~~Copayments. Copayments are assessed in accordance with Section 148.190.~~
- 2) ~~Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

Effective for dates of service on or after July 1, 2014, except those sections specifically designated otherwise:

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Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(a)(b)(1)(A), ~~unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B)~~, for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section. For a hospital that is located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 no new payment or rate increase that would otherwise become effective for dates of

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service on or after July 1, 2010 shall take effect under this Section unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in subsection (g)(5) of this Section no later than six months after the effective date of the first mandatory enrollment in the Coordinated Care Program.

- a) ~~Trauma Center Adjustments (TCA)
The Department shall make a TCA to hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (DPH) in accordance with the provisions of subsections (a)(1) through (a)(4) of this Section. For the purpose of a TCA, a children's hospital, as defined under 89 Ill. Adm. Code 149.50(e)(3), operating under the same license as a hospital designated as a trauma center, shall be deemed to be a trauma center.~~
- 1) ~~Level I Trauma Center Adjustment.~~
 - A) ~~Criteria. Hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by DPH shall receive the Level I trauma center adjustment. Hospitals qualifying under subsection (a)(2) are not eligible for payment under this subsection.~~
 - B) ~~Adjustment. Hospitals meeting the criteria specified in subsection (a)(1)(A) of this Section shall receive an adjustment as follows:~~
 - i) ~~Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$21,365 per Medicaid trauma admission in the CHAP base period.~~
 - ii) ~~Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$14,165 per Medicaid trauma admission in the CHAP base period.~~
- 2) ~~Level I Trauma Center Adjustment for hospitals located in the same city that alternate their Level I trauma center designation.~~
 -
 - A) ~~Criteria. Hospitals that are located in the same city and participate in an agreement in effect as of July 1, 2007, whereby their~~

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~~designation as a Level I trauma center by the Illinois Department of Public Health is rotated among qualifying hospitals from year to year or during a year, that are in the following classes:~~

- ~~i) A children's hospital— All children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3), in a given city, qualifying under subsection (a)(2)(A) shall be considered one entity for the purpose of calculating the adjustment in subsection (a)(2)(B).~~
- ~~ii) A general acute care hospital— All general acute care adult hospitals, in a given city, affiliated with a children's hospital, as defined in subsection (a)(2)(A)(i), qualifying under subsection (a)(2)(A) shall be considered one entity for the purposes of calculating the adjustment in subsection (a)(2)(B).~~

~~B) Adjustment. Hospitals meeting the criteria specified in subsection (a)(2)(A) shall receive an adjustment as follows:~~

- ~~i) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is equal to or greater than the mean Medicaid trauma admissions for the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of \$5,250 per Medicaid trauma admission for that class, in the CHAP base period.~~
- ~~ii) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is less than the mean Medicaid trauma admissions of the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of \$3,625 per Medicaid trauma admission for that class in the CHAP base period.~~

- ~~3) Level II Rural Trauma Center Adjustment. Rural hospitals, as defined in Section 148.25(g)(3), that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of \$11,565 per Medicaid trauma admission in the CHAP base period.~~

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- 4) ~~Level II Urban Trauma Center Adjustment. Urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of \$11,565 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:~~
- A) ~~The hospital is located in a county with no Level I trauma center; and~~
 - B) ~~The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(4) of this Section; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(4) of this Section; and~~
 - C) ~~The hospital does not qualify under subsection (a)(2).~~
- 5) ~~In determining annual payments that are pursuant to the Trauma Center Adjustments as described in this Section, for the CHAP rate period occurring in State fiscal year 2009, total payments will equal the methodologies described in this Section. For the period December 1, 2008 to June 30, 2009, payment will equal the State fiscal year 2009 amount less the amount the hospital received for the period July 1, 2008 to November 30, 2008.~~
- b) ~~Rehabilitation Hospital Adjustment (RHA)~~
~~Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as free-standing acute comprehensive rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(e)(2), and that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission (previously known as the Joint Committee on Accreditation of Healthcare Organizations), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following four components:~~
- 1) ~~Treatment Component. All hospitals defined in subsection (b) of this Section shall receive \$4,215 per Medicaid Level I rehabilitation admission in the CHAP base period.~~

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- ~~2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:
 - ~~A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of \$229,360 in the CHAP rate period.~~
 - ~~B) Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of \$527,528 in the CHAP rate period.~~~~
- ~~3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) of this Section that are located in an HPSA on July 1, 1999, shall receive \$276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.~~
- ~~4) Hospitals qualifying under this subsection (b) that are, as of July 1, 2010, designated as a "magnet hospital" by the American Nurses' Credentialing Center will receive a magnet component of \$1,500,000 annually for the period July 1, 2010 through December 31, 2014.~~

ae) Direct Hospital Adjustment (DHA) Criteria

- 1) Qualifying Criteria
Hospitals may qualify for the DHA under this subsection ~~(a)~~(ae) under the following categories unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006:
 - A) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:
 - i) were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999 and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;

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- ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999 and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or
 - iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(a)(1)(b)(1)(A), and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.
- B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999 and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.
- C) Children's hospitals, as defined under ~~Section 148.25(d)(3)89 Ill. Adm. Code 149.50(e)(3)~~, on July 1, 1999.
- ~~D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.~~
- ~~E) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection (c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one half standard deviation on July 1, 1999 and provided more than 15,000 total days.~~
- ~~F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999 and provided more than 7,500 total days and provided obstetrical care as of July 1, 2001.~~
- ~~G) Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999 that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by~~

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~~the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999 and provided 75 or more Alzheimer days for patients diagnosed as having the disease.~~

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

~~D)~~ Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection ~~(a)(1)(A)(e)(1)(A)~~ through ~~(a)(1)(C)(e)(1)(H)~~ of this Section, all other hospitals that had an MIUR greater than 23 percent on July 1, 1999, had an average length of stay less than four days, provided more than 4,200 total days and provided 100 or more Alzheimer days for patients diagnosed as having the disease.

J) ~~A hospital that does not qualify under subsection (e)(1) of this Section because it does not operate a comprehensive emergency room will qualify if the hospital provider operates a standby emergency room, as defined in 77 Ill. Adm. Code 250.710(e), and functions as an overflow emergency room for its affiliate hospital provider, owned and controlled by the same governing body, that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), within one mile of the hospital provider.~~

2) DHA Rates

A) For hospitals qualifying under subsection ~~(a)(1)(A)(e)(1)(A)~~ of this Section ~~that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will continue to receive the rate in effect as of December 31, 2013, \$105.00 per day for hospitals that do not provide obstetrical care and a rate of \$142.00 per day for hospitals that do provide obstetrical care, for dates of service through June 30, 2014. For dates of service on or after July 1, 2014, the rate is \$0.00, the DHA rates are as follows:~~

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- i) ~~Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive \$69.00 per day for hospitals that do not provide obstetrical care and \$105.00 per day for hospitals that do provide obstetrical care.~~
- ii) ~~Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive \$105.00 per day for hospitals that do not provide obstetrical care and \$142.00 per day for hospitals that do provide obstetrical care.~~
- iii) ~~Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive \$124.00 per day for hospitals that do not provide obstetrical care and \$160.00 per day for hospitals that do provide obstetrical care.~~
- iv) ~~Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive \$142.00 per day for hospitals that do not provide obstetrical care and \$179.00 per day for hospitals that do provide obstetrical care.~~

B) Hospitals qualifying under subsection ~~(a)(1)(A)(e)(1)(A)~~ of this Section with an average length of stay less than 3.9 days will continue to receive the rate in effect as of December 31, 2013, \$254.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00. will also receive the following rates:

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

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- ii) ~~Hospitals that are not county-owned with more than 30,000 total days will have their rate increased by \$354.00 per day for dates of service on or after April 1, 2009.~~
- iii) ~~Hospitals with more than 80,000 total days will have their rate increased by an additional \$423.00 per day.~~
- iv) ~~Hospitals with more than 4,500 obstetrical days will have their rate increased by \$101.00 per day.~~
- v) ~~Hospitals with more than 5,500 obstetrical days will have their rate increased by an additional \$194.00 per day.~~
- vi) ~~Hospitals with an MIUR greater than 74 percent will have their rate increased by \$147.00 per day.~~
- vii) ~~Hospitals with an average length of stay less than 3.9 days will have their rate increased by \$385.00 per day through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$131.00.~~
- viii) ~~Hospitals with an MIUR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999 will have their rate increased by \$360.00 per day for dates of service on or after April 1, 2009.~~
- ix) ~~Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than four days will have their rate increased by \$650.00 per day for dates of service on or after April 1, 2009.~~
- x) ~~Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by \$320.50 per day.~~
- xi) ~~Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have an MIUR greater than 70 percent and have more than 20,000 days will have their rate increased by \$185.00 per day for dates of service on or after April 1, 2009.~~

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xii) ~~Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by \$148.00 per day.~~

C) ~~Hospitals receiving payments under subsection (a)(2)(A) of this Section that have an average length of stay less than four days will continue to have their rate increased by \$650.00 per day for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by \$1,040 per day. For dates of service on or after July 1, 2014, the rate is \$0.00. Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:~~

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

ii) ~~Qualifying hospitals with more than 1,500 obstetrical days will have their rate increased by \$824.00 per day through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$369.00.~~

D) ~~Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate continue to be increased by \$148.00 per diem for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by \$287.00 per day. For dates of service on or after July 1, 2014, the rate is \$0.00. Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:~~

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

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

iii) ~~Hospitals located in Illinois and inside HSA 6 that have an MIUR greater than 80 percent will have their rate increased by \$573.00 per day. For dates of service on or after July 1,~~

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~~2010 through December 31, 2014, this rate shall be increased by an additional \$47.00, to \$620.00.~~

iv) ~~Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by:~~

~~▪ For hospitals that have fewer than 4,000 total days, \$32.00 per day.~~

~~▪ For hospitals that have more than 4,000 total days but fewer than 8,000 total days, \$363.00 per day for dates of service through December 1, 2014; for dates of service on or after January 1, 2015, the rate is \$246.00 per day.~~

~~▪ For hospitals that have more than 8,000 total days, \$295.00 per day for dates of service through December 31, 2014; for dates of service on or after January 1, 2015, the rate is \$178 per day.~~

v) ~~Hospitals with more than 3,200 total admissions will have their rate increased by \$328.00 per day.~~

E) Hospitals qualifying under subsection ~~(a)(1)(B)(e)(1)(D)~~ of this Section that have more than 1,500 obstetrical days will continue to receive the rate in effect as of December 31, 2013, \$224.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00. ~~will receive the following rates:~~

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

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

iii) ~~Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional \$191.00 per day for dates of service on or after April 1, 2009.~~

iv) ~~Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rate increased by an~~

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~~additional \$41.00 per day. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be further increased by \$54.00 per day, to \$95.00 per day.~~

- F) ~~Hospitals qualifying under subsection (a)(1)(C)(e)(1)(E) of this Section that are not located in Illinois, have an MIUR greater than 45 percent, and greater than 4,000 days, will continue to receive the rate in effect as of December 31, 2013, \$117.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00, will receive \$188.00 per day.~~
- G) ~~Hospitals qualifying under subsection (a)(1)(D) of this Section will continue to receive the rate in effect as of December 31, 2013, \$90.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is \$0.00. Hospitals qualifying under subsection (e)(1)(F) of this Section will receive a rate of \$55.00 per day.~~
- H) ~~Hospitals that qualify under subsection (e)(1)(G) of this Section will receive the following rates:~~
- ~~i) Hospitals with an MIUR greater than 19.75 percent will receive a rate of \$69.00 per day.~~
 - ~~ii) Hospitals with an MIUR equal to or less than 19.75 percent, will receive a rate of \$11.00 per day.~~
- I) ~~Hospitals qualifying under subsection (e)(1)(H) of this Section will receive a rate of \$268.00 per day.~~
- J) ~~Hospitals qualifying under subsection (e)(1)(I) of this Section will receive a rate of \$328.00 per day if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$238.00 per day.~~
- K) ~~Hospitals that qualify under subsection (e)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two. The payments calculated under this Section to hospitals that qualify under subsection (e)(1)(A)(iii) of this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate~~

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~~share adjustments for hospitals qualifying under subsection (e)(1)(A)(iii) of this Section.~~

3) DHA Payments

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

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

~~C) For the CHAP rate period occurring in State fiscal year 2011, total payments will equal the methodologies described in subsection (e)(2) of this Section.~~

~~d) Rural Critical Hospital Adjustment Payments (RCHAP)~~

~~RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive \$367,179 per year. The Department shall also make an RCHAP to hospitals qualifying under this subsection at a rate that is the greater of:~~

~~1) the product of \$1,367 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or~~

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

~~e) Total CHAP Adjustments~~

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

~~f) Critical Hospital Adjustment Limitations~~

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

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~~not apply to hospitals qualifying under subsection (a)(2). Payments under this Section are subject to federal approval.~~

be) Critical Hospital Adjustment Payment Definitions

The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

- 1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.
- 2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995 CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996 CHAP rate period; etc.
- 3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.
- 4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120~~(i)(4)(5)~~, plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120~~(i)(5)(6)~~, as of July 1, 1999.
- 5) "Coordinated Care Participating Hospital" means a hospital that is located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 ILCS 5/5-30 that is one of the following:
 - A) Has entered into a contract to provide hospital services to enrollees of the care coordination program.
 - B) Has not been offered a contract by a care coordination plan that pays not less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplement payment that the Department pays directly.
 - C) Is not licensed to serve the population mandated to enroll in the care coordination program.

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- 6) "Medicaid general care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.
- ~~7) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.~~
- ~~8) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.~~
- 79) "Medicaid obstetrical care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with Diagnosis Related Grouping (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.
- ~~10) "Medicaid trauma admission" means those claims billed as admissions for recipients of medical assistance under Title XIX of the Social Security Act that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through~~

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~~852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.~~

- ~~11)~~ "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.
- ~~12)~~ "RCHAP general care admissions" means Medicaid General Care Admissions, as defined in subsection (g)(4) of this Section, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.
- ~~13)~~ "RCHAP obstetrical care admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection (g)(7) of this Section, with a Diagnosis Related Grouping (DRG) of 370 through 375, occurring in the CHAP base period.
- 814) "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
- 915) "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
- 1016) "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; V27 through V27.9; V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

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(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.296 Transitional Supplemental~~Tertiary Care Adjustment~~ Payments

Effective for dates of service on or after July 1, 2014:

To provide stability to the hospital industry in the midst of replacing a twenty year old reimbursement system that relied heavily on non-claims based static payments, in favor of an updated APR-DRG grouper for inpatient services and an entirely new outpatient reimbursement methodology in the EAPG system, the Department shall create transitional supplemental payments to hospitals. These payments are essential to maintaining access to care for an expanding population of Illinois Medical Assistance recipients for a limited time period to allow the hospital providers time to adjust to the new reimbursement policies, rates, and methodologies.

a) Transitional Supplemental Payments shall be made to DRG PPS providers with a simulated payment loss under the new inpatient and outpatient systems combined.

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1) The following providers will not qualify for Transitional Supplemental Payments:

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A) Freestanding psychiatric, rehabilitation, LTAC providers, university-owned large public hospitals, county-owned large public hospitals, children's specialty hospitals and non-cost reporting hospitals.

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B) DRG PPS providers with a simulated payment gain under the new inpatient and outpatient systems combined.

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2) Simulated payment loss or gain under the new inpatient and outpatient systems combined shall be based on:

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A) SFY 2013 legacy system reported claim payments: Reported payments in Illinois Medicaid FFS inpatient and outpatient paid claims data, including Medicare-Medicaid dual eligible claims and non-Medicare eligible claims, for claims with submittal dates during SFY 2013 and admission dates on or after July 1, 2011, excluding outpatient therapy claims, and claims with invalid/ungroupable inpatient DRGs or outpatient EAPGs.

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B) SFY 2013 new system simulated claim payments: Simulated payments under the new inpatient and outpatient systems using

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SFY 2013 claims data described in subsection (a)(2)(A) of this Section, including MPA/MHVA payments and excluding DSH payments and inpatient GME payment increases.

- C) SFY 2011 legacy system supplemental payments, excluding payments that will continue in current form in SFY 2015.
- D) All legacy and new system payment amounts used to determine Transitional Supplemental Payments will be adjusted for SMART Act reductions.
- E) Estimated payment gain or loss under the combined new inpatient and outpatient systems shall be determined as follows: (Simulated new system SFY 2013 claim payments) – [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)].
- F) Estimated payment gain or loss percentage under the combined new inpatient and outpatient systems shall be determined as follows: (Estimated payment gain or loss) / [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)].

b) Transitional Supplemental Payments for qualifying providers shall be the sum of the following components:

- 1) Floor Component: Based on the supplemental payments needed to result in a provider's estimated payment loss of negative three percent, rounded to the nearest thousand dollars, using the following formula:
 - A) [(Reported legacy system SFY 2013 claims payments) + (SFY 2011 legacy system supplemental payments) * 0.97] – (Simulated new system SFY 2013 claim payments).
 - B) A provider with an estimated payment loss percentage less than three percent will have a Floor Component equal to \$0.00.
- 2) Balance Component: Based on a percent of the provider's remaining estimated loss after including the Floor Component, rounded to nearest thousand dollars, using the following formula:

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A) $[(\text{Simulated new system SFY 2013 claims payments}) + (\text{Floor Component})] - [(\text{Reported legacy system SFY 2013 claim payments}) + (\text{SFY 2011 legacy system supplemental payments})]$ * (Balance Adjustment Percentage) * -1.

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B) Balance Adjustment Percentage based on provider type as follows:

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i) Safety Net hospitals: 70 percent

ii) Critical Access hospitals: 70 percent

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iii) Hospital with both Perinatal level III and Trauma level I status: 70 percent

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iv) All other qualifying DRG PPS hospitals with an estimated payment loss: 55 percent.

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c) Timing.

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1) The Department shall make Transitional Supplemental Payments for the first two years of the new inpatient and outpatient payments systems effective during SFY 2015 and 2016.

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2) Commencing October 2015, the Department shall convene a Technical Advisory Group to determine the need to continue any new supplemental payments to maintain access to care, to be effective July 1, 2016. Any new supplemental payments may be based on one or more of the following considerations critical to maintaining access to care for those eligible for Medicaid services:

A) Provider-specific payment increases received from the Medicaid expansion population.

B) Provider-specific Medicaid volume (both total volume and Medicaid utilization rate).

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C) Provider-specific new system payments compared to UPL cost.

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D) Provider-specific new system payments compared to estimated payments under Medicare, using an aggregate Medicare payment-to-charge ratio.

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- E) Provider-specific payments under the hospital assessment.
 - F) Available inpatient and outpatient UPL gap for each provider class.
 - G) The financial implications of the loss of Transitional Supplemental Payments in excess of \$10,000,000 and have an MIUR at least of one and on-half standard deviations above the mean.
 - H) An analysis of new hospital revenues and losses from all sources.
- 3) Effective July 1, 2016, the Department shall direct unused funds from legacy Transitional Supplemental Payments to increase either inpatient DRG PPS base rates or EAPG PPS conversion factors, adjust current policy adjustors defined in subsections 148.140(f) and 149.100(f) if needed, and/or create new policy adjustors, which may include but not be limited to, Perinatal level II or II+ facilities and expensive drugs and devices if needed, based on analysis and recommendations from the Technical Advisory Group defined in subsection (c)(2) of this Section.

~~Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient admissions occurring on or after July 1, 2002, in accordance with this Section.~~

~~a) Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:~~

~~1) "Base Period Claims" means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department through December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in 89 Ill. Adm. Code 149.50(c)(3), be billed by a children's hospital shall be attributed exclusively to the children's facility. Base Period Claims shall exclude the following types:~~

- ~~A) Claims for which Medicare was liable in part or in full ("cross-over" claims);~~
- ~~B) Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and~~

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- ~~C) Claims for services billed for exceptional care services as described at Section 148.50(e)(2)(A) and (B);~~
- 2) ~~"Case Mix Index" or "CMI", for a given hospital, means the sum of all Diagnosis Related Grouping (DRG) (see 89 Ill. Adm. Code 149) weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims:
 - A) ~~Reimbursed under a per diem rate methodology; and~~
 - B) ~~For Delivery or Newborn Care.~~~~
- 3) ~~"Case Mix Adjustment Factor" or "CMAF" means the following:
 - A) ~~For qualifying hospitals located in Illinois that, for Base Period Claims, had a CMI that is greater than the mean:
 - i) ~~CMI of all Illinois cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.040;~~
 - ii) ~~CMI plus one standard deviation above the mean of all Illinois cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.250;~~
 - iii) ~~CMI plus two standard deviations above the mean of all Illinois cost reporting hospitals, the CMAF shall be equal to 0.300.~~~~
 - B) ~~For qualifying hospitals located outside of Illinois that, for Base Period Claims, had a CMI that is greater than the mean:
 - i) ~~CMI of all out of state cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.020;~~
 - ii) ~~CMI plus one standard deviation above the mean of all out of state cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.125;~~~~~~

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- ~~i) number of Qualified Admissions; and~~
 - ~~ii) CMAF; and~~
 - ~~B) The sum of the hospital's:~~
 - ~~i) rate for capital related costs in effect on July 1, 2000; and~~
 - ~~ii) the product of the hospital's CMI raised to the second power and the DRG PPS (Prospective Payment System) (see 89 Ill. Adm. Code 149) rate per discharge in effect on July 1, 2000.~~
- e) ~~DRG Adjustment~~

The Department shall make a DRG Adjustment to certain hospitals, as defined in this subsection (e).

 - 1) ~~Qualifying Hospital. A hospital that, during the Tertiary Adjustment Base Period, had at least one Qualified Admission shall qualify for this payment.~~
 - 2) ~~Qualified Admission. For the purposes of this subsection (e), "Qualified Admission" means a Base Period Claim that was:~~
 - ~~A) Assigned by the Department to a DRG that:~~
 - ~~i) had been assigned a weighting factor greater than 3.2000; and~~
 - ~~ii) for which fewer than 200 Base Period Claims were adjudicated by the Department; and~~
 - ~~B) Not a claim:~~
 - ~~i) reimbursed under a per diem rate methodology;~~
 - ~~ii) for Delivery or Newborn Care; or~~
 - ~~iii) for a patient transferred to another facility as described at 89 Ill. Adm. Code 149.25(b)(2).~~

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- 3) ~~DRG Adjustment Rates. For each Qualified Admission, a Qualifying Hospital will receive a payment equal to the product of:~~
 - A) ~~The hospital's DRG PPS rate per discharge in effect on July 1, 2000; and~~
 - B) ~~The weighting factor assigned to the DRG to which the Qualified Admission was assigned by the Department; and~~
 - C) ~~The constant 1.400.~~

- d) ~~Children's Hospital Adjustment~~

The Department shall make a Children's Hospital Adjustment to certain hospitals, as defined in this subsection (d).

 - 1) ~~Qualifying Hospital. A children's hospital, as defined at 89 Ill. Adm. Code 149.50(e)(3), shall qualify for this payment.~~
 - 2) ~~Qualified Days. For the purposes of this subsection (d), "Qualified Day" means a day of care that was provided in a Base Period Claim, excluding a claim:~~
 - A) ~~For Delivery or Newborn Care;~~
 - B) ~~Assigned by the Department to a DRG with an assigned weighting factor that is less than 1.0000; or~~
 - C) ~~For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).~~
 - 3) ~~Children's Hospital Adjustment. A Qualifying Hospital shall receive a payment equal to the product of:~~
 - A) ~~The sum of Qualified Days from the hospital's Base Period Claims; and~~
 - B) ~~For Illinois hospitals with:~~
 - i) ~~more than 5,000 Qualified Days, \$670.00; or~~
 - ii) ~~5,000 or fewer Qualified Days, \$300.00.~~

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- ~~c) For out of state hospitals with:
 - ~~i) more than 1,000 Qualified Days, \$670.00; or~~
 - ~~ii) 1,000 or fewer Qualified Days, \$300.00.~~~~
- e) Primary Care Adjustment
The Department shall make a Primary Care Adjustment to certain hospitals, as defined in this subsection (e).
 - ~~1) Qualifying Hospital. A hospital located in Illinois that has at least one Qualifying Resident shall qualify for this payment.~~
 - ~~2) Qualifying Residents. For the purposes of this subsection (e), "Qualifying Residents" means the number of primary care residents, as reported on form HCFA 2552-96, Worksheet E-3, Part IV, line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998, used in the fiscal year 2002 Tertiary Care Adjustment Rate Period.~~
 - ~~3) Qualified Admission. For the purposes of this subsection (e), "Qualified Admission" shall mean a Base Period Claim excluding a claim:
 - ~~A) For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b) and reimbursed under a per diem rate methodology; and~~
 - ~~B) For Delivery or Newborn Care.~~~~
 - 4) Primary Care Adjustment. A Qualifying Hospital will receive a payment equal to the product of:
 - A) The number of Qualifying Admissions during the Tertiary Adjustment Base Period;
 - B) \$4,675.00; and
 - C) The quotient of:
 - i) the number of Qualifying Residents;
 - ii) divided by the number of Qualifying Admissions.

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- f) ~~Long Term Stay Hospital Adjustment~~
~~The Department shall make a Long Term Stay Hospital Adjustment to certain hospitals, as defined in this subsection (f).~~
- 1) ~~Qualifying Hospital. A long term stay hospital, as defined at 89 Ill. Adm. Code 149.50(c)(4), that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, shall qualify for this payment.~~
- 2) ~~Qualified Days. For the purposes of this subsection (f), "Qualified Day" means a day of care that was provided in a Base Period Claim, excluding claims for hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).~~
- 3) ~~Long Term Stay Hospital Adjustment Rates. A Qualifying Hospital will receive payments equal to the product of:~~
- A) ~~The number of Qualified Days from all Base Period Claims; and~~
- B) ~~A constant that:~~
- i) ~~for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, \$3,000.00; or~~
- ii) ~~for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, but less than one standard deviation above that mean, \$5.00.~~
- g) ~~Rehabilitation Hospital Adjustment~~
~~The Department shall make a Rehabilitation Hospital Adjustment to certain hospitals as defined in this subsection (g).~~
- 1) ~~Qualifying Hospital. A hospital that qualifies for the Rehabilitation Hospital Adjustment under the Critical Hospital Adjustment Payments (CHAP) program, as defined in Section 148.295(b), shall qualify for this payment.~~
- 2) ~~Qualified Admission. For the purposes of this subsection (g), "Qualified Admission" shall mean a Medicaid level I rehabilitation admission in the CHAP rate period, as defined in Section 148.295, for fiscal year 2001.~~

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- 3) ~~Rehabilitation Hospital Adjustment. A Qualifying Hospital shall receive payment as follows:~~
 - A) ~~For a hospital that had fewer than 60 Qualified Admissions, \$100,000.00.~~
 - B) ~~For a hospital that had 60 or more Qualified Admissions, \$350,000.00.~~
- h) ~~Tertiary Care Adjustment~~
 - 1) ~~The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (a) through (g) of this Section multiplied by 0.455.~~
 - 2) ~~A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.~~
 - 3) ~~For hospitals qualifying for payments under this Section, adjustment periods occurring in State fiscal year 2009, total payments will equal the sum of amounts calculated under the methodologies described in this Section and shall be paid to the hospital during the Tertiary Care Adjustment Rate period.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.297 Physician Development Incentive Payments~~Pediatric Outpatient Adjustment Payments~~

Effective for dates of service on or after July 1, 2014:

- a) A Medicaid Graduate Medical Education (GME) fund in Illinois will support and align with the State's current and projected physician workforce needs and goals including:
 - 1) increasing the number of primary care providers in Illinois,
 - 2) increasing the number of primary care providers working in medically underserved areas, and

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- 3) increasing the number of providers who are trained to practice in a patient-centered medical home setting within an integrated delivery system.

- b) The performance criteria for incentive payments of the program will be as follows:
 - 1) 50 percent of funds are set aside for GME program resident continuity clinics meeting standards for at least one of the following:
 - A) Level II or III Patient Centered Medical Homes by the National Center for Quality Assurance.
 - B) Primary Care Medical Home Certification by the Joint Commission.
 - C) Medical Home Accreditation by the Accreditation Association for Ambulatory Health Care.

Each program within a hospital meeting one of these certification or accreditation standards will receive an equal share of these funds.
 - 2) 25 percent of funds will be set aside for resident practice clinics with significant medically underserved populations.

Each program within a hospital meeting these standards will receive an equal share of these funds.
 - 3) 25 percent of funds set aside for written curricula in population medicine based on practice in continuity of care settings. The curriculum must contain competencies in population medicine. Population medicine curriculum competencies should include: preventive medicines; information technology for managing continuity of care practice panels; managing transitions of care; participating in team-based care and supporting patient-centered decision making. Programs must document that all residents received at least 20 hours a year in instruction in these areas.

Each program within a hospital meeting these standards will receive an equal share of these funds.

- c) Residency programs and the sponsoring medical centers will collect all information to be submitted for this program to HFS by June 1, each GME rate

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year. This includes, proof of certification requirements required in subsection (b)(1), internal GME residency program data, and queries of GME program recent graduates.

- d) The submitted data from eligible GME programs will be reviewed for meeting program performance standards. The Department may require for corroborating information and audit, any submission.
- e) All GME residency programs meeting performance standards and qualifying to receive program funding will be announced annually. Subsequent to its determination of qualifying programs, the Department will disburse program funds to the hospitals that sponsor qualifying GME residence programs.
- f) The Department shall recover – through repayment by or recoupment against other funds payable to, the hospital – program funds that have been found to have been disbursed in error.
- g) Definitions.
 - 1) “GME” means graduate medication education.
 - 2) “GME rate year” means the twelve-month period beginning on July 1 of each year; with the first GME rate year to begin on July 1, 2014.
 - 3) “Primary care GME programs” means either Accreditation Council on Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) Post Graduate accredited residency programs in Family Medicine, Internal Medicine, Pediatrics and Internal Medicine-Pediatrics. Programs that are dual accredited by the ACGME and AOA are only eligible for a single yearly payment.
 - 4) “Significant medically underserved populations” means more than 50 percent of the individuals served by a qualifying residency practice clinic enrolled Medicaid or are uninsured. The denominator used in this calculation shall include all resident continuity clinics in a GME program practice. When more than one site is used for resident continuity of care practice, the designated practice site or sites used to calculate percent medically underserved must contain greater than 75% of all patients seen by residents in continuity practice.

Pediatric Outpatient Adjustment Payments shall be made to all eligible hospitals excluding county owned hospitals, as described in Section 148.25(b)(1)(A), and

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~~hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for outpatient services occurring on or after July 1, 1998, in accordance with this Section.~~

- a) ~~To qualify for payments under this Section, a hospital must:~~
 - 1) ~~be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), and~~
 - 2) ~~have a Pediatric Medicaid Outpatient Percentage greater than 80 percent during the Pediatric Outpatient Adjustment Base Period.~~

- b) ~~Hospitals qualifying under this Section shall receive the following amounts for the Pediatric Outpatient Adjustment Rate Year for dates of services occurring on or after July 1, 1999:~~
 - 1) ~~For out-of-state cost reporting hospitals with an MIUR that is less than 75 percent, the product of:~~
 - A) ~~the hospital's MIUR plus 1.15, multiplied by~~
 - B) ~~the number of Pediatric Adjustable Outpatient Services, multiplied by~~
 - C) ~~\$169.00.~~
 - 2) ~~For Illinois hospitals with an MIUR that is less than 75 percent, the product of:~~
 - A) ~~the hospital's MIUR plus one, multiplied by~~
 - B) ~~the number of Pediatric Adjustable Outpatient Services, multiplied by~~
 - C) ~~\$169.00.~~
 - 3) ~~For Illinois hospitals with an MIUR that is greater than or equal to 75 percent, the product of:~~
 - A) ~~one and one-half the hospital's MIUR plus one, multiplied by~~
 - B) ~~the number of Pediatric Adjustable Outpatient Services, multiplied by~~

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~~€) \$305.00.~~

- ~~e) In addition to the reimbursement rates described in subsection (b) of this Section, hospitals that have an MIUR that is greater than or equal to 80 percent shall receive an additional \$229,740.00 during the Pediatric Outpatient Adjustment Rate Year.~~
- ~~d) Adjustments under this Section shall be paid at least quarterly.~~
- ~~e) Definitions~~
 - ~~1) "Medicaid Inpatient Utilization Rate" or "MIUR", as used in this Section, has the same meaning as ascribed in Section 148.120(i)(5), in effect for the rate period October 1, 1996, through September 30, 1997.~~
 - ~~2) "Pediatric Adjustable Outpatient Services" means the number of outpatient services, excluding procedure code 0080, adjudicated through a UB92 billing form and grouped through the Hospital Ambulatory Care Groupings, as defined in Section 148.140(b)(1), during the Pediatric Outpatient Adjustment Base Period. For a hospital, which includes a facility devoted exclusively to caring for children, that is separately licensed as a hospital by a municipality, Pediatric Adjustment Outpatient Services will include psychiatric services (categories of service 27 or 28) for children less than 18 years of age, that are billed through the affiliated general care hospital.~~
 - ~~3) "Pediatric Medicaid Outpatient Percentage" means a percentage that results from the quotient of the total Pediatric Adjustable Outpatient Services for persons less than 18 years of age divided by the total Pediatric Adjustable Outpatient Services for all persons, during the Pediatric Outpatient Adjustment Base Period.~~
 - ~~4) "Pediatric Outpatient Adjustment Base Period" means all services billed to the Department, excluding procedure code 0080, with State Fiscal Year 1996 dates of service that were adjudicated by the Department on or before March 31, 1997.~~
 - ~~5) "Pediatric Outpatient Adjustment Rate Year" means State Fiscal Year 1998 and each State Fiscal Year thereafter.~~

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- f) ~~For hospitals qualifying for payments under this Section, adjustment periods occurring in State fiscal year 2009, total payments will equal the sum of amounts calculated under the methodologies described in this Section and shall be paid to the hospital during the Pediatric Outpatient Adjustment Rate year.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.298 Pediatric Inpatient Adjustment Payments (Repealed)

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~~Pediatric Inpatient Adjustment Payments shall be made, on a quarterly basis, to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient services occurring on or after July 1, 1998, in accordance with this Section:~~

- a) ~~To qualify for payments under this subsection (a), a hospital must be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(e)(3), that was licensed by a municipality on or before December 31, 1997. Hospitals qualifying under this subsection shall receive an adjustment for inpatient services equal to the product of the hospital's psychiatric and physical rehabilitation days, provided to children under 18 years of age during the adjustment base year, multiplied by \$816.00 per day. Payments under this subsection will based on the following methodology:~~
- 1) ~~The calculation under this subsection (a) may not exceed more than 850 days.~~
- 2) ~~For the purposes of calculating payments under this subsection (a), the adjustment base year shall be psychiatric and physical rehabilitation days of care provided by the portion of the hospital that the Department does not recognize as a children's hospital. Such days include those provided in State fiscal year 1997 and adjudicated by the Department through March 31, 1998.~~
- b) ~~In addition to the payments described under subsection (a) of this Section, any children's hospital, as defined in 89 Ill. Adm. Code 149.50(e)(3), will receive an additional adjustment equal to the product of the hospital's total paid days, excluding Medicare crossover claims, multiplied by \$113.00 per day. Such days include those provided in State fiscal year 1999 and adjudicated by the Department through May 31, 1999.~~
- e) ~~For rate years occurring after State fiscal year 2000, total payments made under subsections (a) and (b) of this Section shall be paid at least quarterly.~~

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(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.300 Payment

Effective for dates of service on or after July 1, 2014:

- a) The Department will adjust rate methodologies used to reimburse hospitals to assure compliance with applicable aggregate and hospital-specific federal payment limitations.
- b) Effect of Change of Ownership on Payments. When a hospital's ownership changes payment for hospital services for each patient, including payment adjustments, will be made to the entity that is the legal owner on the date of discharge. Payment will not be prorated between the buyer and seller.
 - 1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished regardless of when the client's coverage began or ended during a stay, or how long the stay lasted.
 - 2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the information is attributable to a period during which a different party legally owned the hospital.
- c) Notwithstanding any other provisions of 89 Ill. Adm. Code Parts 148, 149, or 152, a hospital that is located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as defined in section 5-30 of the Illinois Public Aid Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of the Illinois Public Aid Code that it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital as defined in 89 Ill. Adm. Code 148.25(f), no later than August 14, 2012, or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care Program.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.310 Review Procedure

Effective for dates of service on or after July 1, 2014:

- a) ~~Inpatient~~ Rate Reviews

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Hospitals shall be notified of their rates for the rate year and shall have an opportunity to request a review, pursuant to subsection (f), of any rate for errors in calculation made by the Department.

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~~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, pursuant to subsection (f), 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~~

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~~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(i)(4)~~~~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(i)(4)~~~~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, as defined in Section 148.120(a)(2) ~~and (d), and Section 148.122(a)(2) and (e)~~. 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

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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(g)(3)~~ ~~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, pursuant to subsection (f), 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

Cost report reviews are described in Section 148.210(a)

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- 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(e). 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.~~

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- 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.~~

ef) **Medicaid High Volume Adjustment Reviews**
The Department shall make Medicaid high volume adjustments in accordance with Section ~~148.112~~148.290(d). Hospitals shall be notified of the Department's determination and have an opportunity to request a review, pursuant to subsection (f). ~~That review~~ 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.~~

f) **Rate Review Requirements**

- 1) All requests for review must be submitted in writing and must either be received by the Department, or post marked within 30 days after the date of the Department's notice to the hospital. Such request shall include:
 - A) a clear explanation of any suspected error,
 - B) any additional documentation to be considered, and

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

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2) 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.

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

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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.~~

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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.~~

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- ~~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~~

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~~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~~

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~~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~~

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~~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~~

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~~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.~~

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~~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~~

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~~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~~

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~~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.~~

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- 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.~~
- ee) ~~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~~

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~~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.~~

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- 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~~

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~~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.~~

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- ~~h) 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) 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) 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

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~~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 38 Ill. Reg. _____, effective _____)

Section 148.320 Alternatives ~~(Repealed)~~

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- a) ~~The provisions of Sections 148.250 through 148.310 of this Part shall be in effect during the fiscal year for so long as the Director of the Department finds that:~~
- ~~1) The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this Part is sufficient to assure that medical assistance recipients have reasonable access to hospital services. In making this determination, factors considered by the Department include but are not limited to service availability and the number of recipients within a geographic area, recipient travel time to obtain services, and availability of a range of services within the geographic area.~~
 - ~~2) The provisions are approved by the Department of Health and Human Services in the State Title XIX Plan.~~
 - ~~3) The Department has not been enjoined, restrained of otherwise delayed or prohibited by Court order or actions of entities other than the Department from enforcing the provisions.~~
- b) ~~If any of the conditions specified above fail to occur, alternative service coverage and reimbursement limitations shall be implemented to assure that payments for hospital services during a fiscal year will be approximately the same as would have been made under this Part.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.330 Exemptions

Effective for dates of service on or after July 1, 2014:

Nothing in these rules is intended to prevent a hospital from individually negotiating with the Department to set up an alternate methodology for reimbursement that result results in an expenditure which does not exceed the expenditure which would otherwise be made under this subchapter rule.

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(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.370 Payment for Sub-acute Alcoholism and Substance Abuse Treatment Services

Effective for dates of service on or after July 1, 2014:

- a) The amount approved for payment for sub-acute alcoholism and substance abuse treatment is based on the type and amount of services required by and actually delivered to a recipient. The amount is determined in accordance with prospective rates developed by the Department of Human Services and approved and adopted by the Department ~~of Public Aid~~ (see 77 Ill. Adm. Code 2090.70). The adopted rate shall not exceed the charges to the general public.
- b) Rates are generated through the application of formal methodologies specific to each category in accordance with the specifications in 77 Ill. Adm. Code 2090.35, 2090.40 and 2090.70. Rate appeals are allowable pursuant to the specifications in 77 Ill. Adm. Code 2090.80.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.390 Hearings

Effective for dates of service on or after July 1, 2014:

- a) The Department may initiate administrative proceedings pursuant to Subpart C, of 89 Ill. Adm. Code Part 104, ~~Subpart C,~~ to suspend or terminate certification and eligibility to participate in the Illinois Medical Assistance Program where the provider:
 - 1) Has failed to comply with 77 Ill. Adm. Code 2090.40; ~~and/or~~
 - 2) Does not have a valid license for an enrolled treatment service category
 - 3) Any of the grounds for payment recovery or termination set forth in 89 Ill. Adm. Code 140.15, ~~or~~ 140.16 or Subpart C of 89 Ill. Adm. Code 104 are present.
- b) When a proceeding is initiated against providers of alcoholism or substance abuse services, the Department shall notify the provider of the intended action(s). Notice, service and proof of service shall be in accordance with the "Rules of

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Practice For Medical Vendor Administrative Proceedings" (Subpart C of 89 Ill. Adm. Code 104-Subpart C).

- c) All hearings held pursuant to these rules shall be conducted by an attorney designated by the Director of the Department as a hearing officer and said hearing shall be conducted under and governed by the applicable "Rules of Practice For Medical Vendor Administrative Proceedings" promulgated by the Department (Subpart C of 89 Ill. Adm. Code 104-Subpart C).
- d) The hearing officer shall prepare a written report of the case which shall contain findings of fact and recommended decisions with regard to the issues of recoupment, certification and continued participation in the Medicaid Program. The ~~Associate~~ Director of the ~~Division Office~~ of Alcoholism and Substance Abuse (Department of Human Services) ~~may shall~~ also make a recommendation ~~that final shall be~~ in writing and ~~forward forwarded~~ to the Director of ~~the Department~~ ADPA. The Director of the Department shall then make a final decision based on the findings of fact and all recommendations. A final administrative decision shall be issued in writing and contain findings of fact and the final determinations concerning recoupment, certification and continued participation in the Medicaid Program. A copy of the decision shall be served on each party.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.400 Special Hospital Reporting Requirements

Effective for dates of service on or after July 1, 2014:

Corrective Action Plans. Hospitals are responsible for assuring that services provided to Medical Assistance Program Medicaid program participants meet or exceed the appropriate standards for care. Any provider that is under any corrective action plan(s), while enrolled with the Department, by any licensing, certification and/or accreditation authority, including, but not limited to, the Illinois Department of Public Health, the ~~federal Federal~~ Department of Health and Human Services, a peer review organization, ~~and/or The Joint Commission (TJC) the Joint Commission for Accreditation of Health Care Organization~~, must report the request for such corrective action plans to the Department. Information submitted will remain confidential.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.440 High Volume Adjustment Payments

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- a) Qualifying criteria. With the exception of a large public hospital, a High Volume Adjustment payment shall be made to each general acute care hospital that provided and was paid for more than 20,500 Medicaid inpatient days.
- b) Payment. Qualifying hospitals shall receive an annual payment that is the product of the hospital's Medicaid inpatient days and:
 - 1) \$350, for a hospital with a case mix index greater than or equal to the 85th percentile for all qualifying hospitals.
 - 2) \$100, for any other hospital.
- c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.442 Inpatient Services Adjustment Payments

- a) Qualifying criteria. With the exception of a large public hospital, all Illinois hospitals qualify for the Inpatient Services Adjustment payment.
- b) Payment. A hospital shall receive an annual payment that is the sum of the following amounts for which it qualifies:
 - 1) A general acute care hospital shall receive an annual amount that is equal to 40% of its base inpatient payments.
 - 2) A freestanding specialty hospital shall receive an annual amount that is equal to 60% of its base inpatient payments.
 - 3) A children's hospital shall receive an annual amount that is equal to 20% of its base inpatient payments.
 - 4) A children's hospital shall receive an annual amount that is equal to 20% of its payments for inpatient psychiatric services provided during State fiscal year 2005.
 - 5) An Illinois hospital licensed by the Illinois Department of Public Health (IDPH) as a psychiatric or rehabilitation hospital shall receive an annual amount that is equal to the product of the following factors:
 - A) Medicaid inpatient days.

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- B) \$1,000.
- C) The positive percentage of change in the hospital's MIUR between 2005 and 2007.
- 6) A children's hospital shall receive an annual amount that is the product of the annual payment ~~as defined in~~ ~~described in~~ Section 148.298 ~~on~~ December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, multiplied by:
 - A) 2.50, for a hospital that is a freestanding children's hospital
 - B) 1.00, for any other hospital.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.444 Capital Needs Payments

- a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital with a 2007 MIUR of 10% or greater qualifies for the Capital Needs payment.
- b) Payment. Qualifying hospitals shall receive an annual payment that is the product of the hospital's Medicaid inpatient days and:
 - 1) The difference between the hospital's capital cost per diem and 75th percentile for all hospitals, for hospitals with a 2007 MIUR of 0.3694 or greater with a capital cost per diem that is less than the 75th percentile for all hospitals.
 - 2) The difference between the hospital's capital cost per diem and 60th percentile for all hospital, for any other hospital

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.446 Obstetrical Care Payments

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- a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital qualifies for the Obstetrical Care payment if the hospital is one of the following:
- 1) A rural hospital, ~~as defined~~ as being located outside a metropolitan statistical area; or located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health and must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993) in Section 148.25(g)(3), with a Medicaid obstetrical rate greater than 15%.
 - 2) Classified, on December 31, 2006, as a perinatal level III hospital by IDPH and that had a case mix index equal to or greater than the 45th percentile of such perinatal level III hospitals.
 - 3) Classified, on December 31, 2006, as a perinatal level II or II+ hospital by IDPH and that had a case mix index equal to or greater than the 35th percentile, of such perinatal level II and II+ hospitals combined.
- b) Payment. Qualifying hospitals shall receive an annual payment that is the product of the hospital's Medicaid obstetrical days and:
- 1) \$1,500, for a hospital qualifying under subsection (a)(1) of this Section.
 - 2) \$1,350, for a hospital qualifying under subsection (a)(2) of this Section.
 - 3) \$900, for a hospital qualifying under subsection (a)(3) of this Section.
- c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.448 Trauma Care Payments

- a) Qualifying criteria. With the exception of a large public hospital, a hospital qualifies for this payment if the hospital is one of the following:

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- 1) A general acute care hospital that, as of July 1, 2007, was designated by IDPH as a trauma center.
 - 2) A children's hospital, located in a contiguous state, that has been designated a trauma hospital by that State providing more than 8,000 Illinois Medicaid days.
- b) Payment. A hospital shall receive an annual payment that is the sum of the following amounts for which it qualifies:
- 1) The product of the hospital's Medicaid inpatient general acute care days and \$400, for a general acute care hospital designated as a Level II trauma center as identified in 89 Ill. Adm. Code 148.295(a)(3) and (a)(4) as of December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.
 - 2) The product of the amount of the State fiscal year 2005 Medicaid capital payments and the factor of 3.75, for a general acute care hospital designated as a trauma center as ~~defined identified~~ in 89 Ill. Adm. Code 148.295(a) on December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.
 - 3) The product of the hospital's Medicaid general acute care inpatient days and \$235, for a hospital that qualifies under (a)(2) of this Section
- c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.450 Supplemental Tertiary Care Payments

- a) Qualifying criteria. An Illinois hospital that qualified in State fiscal year 2007 for a payment described in Section 148.296, as was in effect on December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.
- b) Payment. A hospital shall receive an annual payment that is equal to the amount for which it qualified in State fiscal year 2007 in Section 148.296, as was in effect on December 31, 2013, as seen in,

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<http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.452 Crossover Care Payments

- a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital that had a ratio of crossover days to total medical assistance inpatient days (utilizing information from 2005 Illinois medical assistance paid claims) greater than 50% and the hospital's case mix index is equal to or greater than the 65th percentile of all case mix indices.
- b) Payment. A qualifying hospital shall receive an annual payment that is the product of \$1,125 and the inpatient days provided to individuals eligible for Medicaid, as recorded in the Department's paid claims data.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.454 Magnet Hospital Payments

- a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital or a freestanding children's hospital qualifies for Magnet Hospital payment if it meets both of the following criteria:
 - 1) Was, as of February 1, 2008, designated as a "magnet hospital" by the American Nurses' Credentialing Center.
 - 2) A case mix index that is equal to or greater than the 75th percentile for all hospitals.
- b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid inpatient days, eligibility growth factor, and:
 - 1) \$450, for a hospital that has a case mix index equal to or greater than the 75th percentile of all hospitals and an eligibility growth factor that is greater than the mean eligibility growth factor for counties in which the hospital is located.

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- 2) \$225, for a hospital that has an eligibility growth factor that is less than or equal to the mean eligibility growth factor for counties in which the hospital is located.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.456 Ambulatory Procedure Listing Increase Payments

- a) Qualifying criteria. With the exception of a large public hospital, as defined in Section 148.458(a) Ambulatory Procedure Listing Increase payment shall be shall be made to each Illinois hospital.

- b) Payment. Qualifying hospitals shall receive an annual payment that is the sum of:

- 1) For a hospital that is licensed by the Department of Public Health as a psychiatric specialty hospital, the product of:

- A) The hospital's payments for type B psychiatric clinic services provided during State fiscal year 2005 that reimbursed through methodologies ~~defined described~~ in subsection 148.140(b)(1)(e) on December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>; and,

- B) 3.25.

- 2) For all other hospitals:

- A) The hospital's payments for services provided during State fiscal year 2005 that reimbursed through methodologies ~~defined described~~ in Sections 148.140(b)(1)(A) through 148.140(b)(1)(D) December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>; and,

- B) 2.20.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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Section 148.458 General Provisions

Unless otherwise indicated, the following apply to Sections 148.440 through 148.456.

a) Definitions

"Base inpatient payments" means, for a given hospital, the sum of payments made using the rates ~~defined in Section 148(b)(1)~~ for services provided during State fiscal year 2005 and adjudicated by the Department through March 23, 2007.

"Capital cost per diem" means, for a given hospital, the quotient of (i) the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by (ii) the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department shall use the data reported on the hospital's 2005 Medicaid cost report.

"Case mix index" means, for a given hospital, the quotient resulting from dividing (i) the sum of the all diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, by (ii) the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

"Children's hospital" means a hospital as described in Section 149.50(c)(3).

"Eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

"Freestanding children's hospital" means an Illinois Children's hospital that is licensed by the Illinois Department of Public Health as a pediatric hospital.

"Freestanding specialty hospital" means an Illinois hospital that is neither a general acute care hospital nor a large public hospital nor a freestanding children's hospital.

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"General acute care hospital" means an Illinois hospital that operates under a general license (i.e., is not licensed by the Illinois Department of Public Health as a psychiatric, pediatric, rehabilitation, or tuberculosis specialty hospital) and is not a long term stay hospital, as described in Section ~~148.25(d)(4)~~~~149.50(e)(4)~~.

"Large public hospital" means a county-owned hospital, as described in Section 148.25~~(a)(b)(1)(A)~~, a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25~~(a)(b)(1)(B)~~, or a hospital owned or operated by a State agency, as described in Section 148.25~~(a)(b)(6)~~.

"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), for admissions occurring during State fiscal year 2005 as adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to Illinois recipients of medical assistance under Title XIX of the federal Social Security Act, assigned a diagnosis related group code of 370 through 375, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005, adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical rate" means, for a given hospital, a fraction, the numerator of which is the hospital's Medicaid obstetrical days and the denominator is the hospital's Medicaid inpatient days.

"Medicare crossover rate" means, for a given hospital, a fraction, the numerator of which is the number patient days provided to individuals eligible for both Medicare under Title XVIII and Medicaid under Title XIX of the federal Social Security Act and the denominator of which is the number patient days provided to individuals eligible for medical programs administered by the Department, both as recorded in the Department's paid claims data.

"MIUR" means Medicaid inpatient utilization rate as defined in Section ~~148.120(i)(4)~~~~148.120(k)(4)~~.

b) Payment

- 1) The annual amount of each payment for which a hospital qualifies shall be made in 12 equal installments on or before the seventh State business day

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of each month. If a hospital closes or ceases to do business, payments will be prorated based on the number of days the hospital was open during the State fiscal year in which the hospital closed or ceased to do business.

- 2) Monthly payments may be combined into a single payment to a qualifying hospital. Such a payment will represent the total monthly payment a qualifying hospital receives pursuant to Sections 148.440 through 148.456.
- 3) The Department may adjust payments made pursuant to Article V-A of the Public Aid Code to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.
- 4) If the federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under Article V-A of the Illinois Public Aid Code is exceeded, then the payments under Article V-A of the Illinois Public Aid Code that exceed the applicable federal upper limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

c) Rate Reviews

- 1) A hospital shall be notified in writing of the results of the payment determination pursuant to Sections 148.440 through 148.456.
- 2) Hospitals shall have a right to appeal the calculation of, or their ineligibility for, payment if the hospital believes that the Department has made a technical error. The appeal must be submitted in writing to the Department and must be received or postmarked within 30 days after the date of the Department's notice to the hospital of its qualification for the payment amounts, or a letter of notification that the hospital does not qualify for 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.

d) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.460 Catastrophic Relief Payments **(Repealed)**

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- a) ~~Qualifying Criteria. Catastrophic Relief Payments, as described in this subsection (a), shall be made to Illinois hospitals, except publicly owned or operated hospitals or a hospital identified under 89 Ill. Adm. Code 149.50(c)(3)(B), that have an MIUR greater than the current statewide mean, are not a publicly owned hospital, and are not part of a multiple hospital network, unless the hospital has an MIUR greater than the current statewide mean plus two standard deviations. Payments to qualifying hospitals will be based on the criteria described in this Section.~~
- b) ~~Payments~~
- 1) ~~An Illinois hospital qualifying under subsection (a) of this Section that is a general acute care hospital with greater than 3,000 Medicaid admissions and a case mix greater than 70% will receive the greater of:~~
- A) ~~Medicaid admissions multiplied by \$2,250; or~~
- B) ~~\$8,000,000.~~
- 2) ~~An Illinois hospital qualifying under subsection (a) of this Section that received payments under Section 148.456 will receive the greater of:~~
- A) ~~2% of the annual Outpatient Ambulatory Procedure Listing Increase Payments, as defined in Section 148.456; or~~
- B) ~~\$175,000.~~
- 3) ~~With the exception of psychiatric hospitals, a hospital qualifying under subsection (a) of this Section will receive the following:~~
- A) ~~\$1,750,000 for Illinois hospitals with more than 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
- B) ~~\$1,600,000 for Illinois hospitals with 20 to 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
- C) ~~\$750,000 for Illinois hospitals with up to 20 Title XXI admissions in the Catastrophic Relief Payments base period.~~
- 4) ~~A psychiatric hospital qualifying under subsection (a) of this Section will receive the following:~~

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- A) ~~\$1,312,500 for an Illinois hospital with more than 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
 - B) ~~\$1,200,000 for an Illinois hospital with 20 to 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~
 - C) ~~\$562,500 for an Illinois hospital with up to 20 Title XXI admissions in the Catastrophic Relief Payments base period.~~
 -
 - 5) ~~Payments under this Section are effective for State fiscal year 2009. Payments are not effective for dates of service on or after July 1, 2009.~~
- e) **Definitions**
- 1) ~~"MIUR", for a given hospital, has the meaning ascribed in Section 148.120(i)(4) and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2009 shall be the same determination used to determine a hospital's eligibility for Catastrophic Relief Payments in the Adjustment Period.~~
 - 2) ~~"General acute care hospital" is a hospital that does not meet the definition of a hospital ascribed in 89 Ill. Adm. Code 149.50(e).~~
 - 3) ~~"Title XXI admissions" means recipients of medical assistance through the Illinois State Child Health Plan under Title XXI of the Social Security Act.~~
 - 4) ~~"Catastrophic Relief Payments base period" means the 12-month period beginning on July 1, 2006 and ending June 30, 2007.~~
 - 5) ~~"Psychiatric hospital" is a hospital as defined in 89 Ill. Adm. Code 149.50(e)(1).~~
 - 6) ~~"Case mix index" means, for a given hospital, the quotient resulting from dividing the sum of all the diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82, by the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82.~~

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- 7) ~~"Medicaid admissions" means State fiscal year 2007 hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the 2009 CHAP (Section 148.295) rate period and contained within the Department's paid claims database, for recipients of medical assistance under Title XIX of the Social Security Act, excluding Medicare/Medicaid crossover admissions.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.462 Hospital Medicaid Stimulus Payments (Repealed)

~~One-time payments shall be made to all eligible Illinois hospitals, for inpatient and outpatient Medicaid services occurring on or after December 10, 2009, in accordance with this Section. The total payment shall be the sum of the following payment methodologies:~~

- a) ~~Rural Emergency Services Stimulus Adjustment (RESA)~~
- 1) ~~Qualifying Criteria~~
- A) ~~Rural Illinois hospitals, as defined at 89 Ill. Adm. Code 148.25(g)(3), licensed by the Department of Public Health (IDPH) under the Hospital Licensing Act, certified by IDPH to participate in the Illinois Medicaid Program, and enrolled with the Department of Healthcare and Family Services to participate in the Illinois Medicaid Program; and~~
- B) ~~Provide services as required under 77 Ill. Adm. Code 250.710 in an emergency room subject to the requirements under either 77 Ill. Adm. Code 250.2440(k) or 77 Ill. Adm. Code 250.2630(k).~~
- 2) ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental outpatient payment equal to the hospital's outpatient ambulatory procedure listing payments for Group 3 services, as defined in Section 148.140(b)(1)(C), except that a qualifying hospital designated as a critical access hospital by IDPH in accordance with 42 CFR 485, subpart F (2001) as of July 1, 2009 shall have the payment determined under subsection (a)(2)(A) of this Section multiplied by 3.5, rounded to the nearest whole dollar.~~
- b) ~~Obstetrical Care Severity and Volume Stimulus Adjustment (OCSVSA)~~
- 1) ~~Qualifying Criteria~~

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~~With the exception of a large public hospital, a hospital designated as of July 1, 2009 by IDPH as a Perinatal Level III facility in accordance with 77 Ill. Adm. Code 250.1820(f)(1)(C) and that provided more than 2,000 Medicaid obstetrical days.~~

~~2) Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~A) The hospital's Medicaid obstetrical days; and~~

~~B) \$175.00.~~

~~e) Illinois Trauma Center Stimulus Adjustment (ITCA)~~

~~1) Qualifying Criteria~~

~~With the exception of a large public hospital, a hospital designated as of July 1, 2009 by IDPH as a Level I Trauma Center in accordance with 77 Ill. Adm. Code 515.2030 or 515.2035. For the purposes of this payment, hospitals located in the same city that alternate their Level I Trauma Center designation in accordance with 89 Ill. Adm. Code 148.295(a)(2)(A) shall each be deemed eligible for the payment under this Section.~~

~~2) Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~A) The hospital's Medicaid inpatient days; and~~

~~B) \$22.00.~~

~~d) Acute Care Across the Board Stimulus Adjustment (ABSA)~~

~~1) Qualifying Criteria~~

~~An Illinois hospital, with the exception of a large public hospital and a hospital identified in 89 Ill. Adm. Code 149.50(e)(4).~~

~~2) Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~A) The hospital's Medicaid inpatient days; and~~

~~B) \$37.00.~~

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- e) ~~High Volume Medicaid Dependent Provider Stimulus Adjustment (HVMDA)~~
 - 1) ~~Qualifying Criteria~~
~~With the exception of a large public hospital and hospitals identified in 89 Ill. Adm. Code 149.50(c)(1), (c)(2) and (c)(4), an Illinois hospital qualifying for designation under 89 Ill. Adm. Code 148.120 or 148.122 for the rate year beginning October 1, 2009 and ending September 30, 2010.~~
 - 2) ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~
 - A) ~~The hospital's Medicaid inpatient days; and~~
 - B) ~~\$35.00.~~
- f) ~~Adjustments and Limitations~~
 - 1) ~~The provisions of this Section shall be in effect:~~
 - A) ~~Upon approval by the Department of Health and Human Services in the Title XIX State Plan; and~~
 - B) ~~As soon as practicable after the effective date of P.A. 96-821; and~~
 - C) ~~As long as the payments under Sections 148.440 through 148.456 remain eligible for federal match under an approved State Plan Amendment, but not beyond December 31, 2010.~~
 - 2) ~~No hospital shall be eligible for payment under this Section that:~~
 - A) ~~Ceases operations prior to federal approval of, and adoption of, administrative rules necessary to effect payments under this Section; or~~
 - B) ~~Has filed for bankruptcy or is operating under bankruptcy protection under any chapter of USC 11 (Bankruptcy Code); or~~
 - C) ~~Discontinues providing a service recognized by one of the payments for which it qualifies; or~~

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- ~~D) Surrenders a license or designation recognized by one of the payments, or has a designation or certification revoked by the authorizing agency or entity.~~
- 3) ~~The Department may pay a portion of payments made under this Section in a subsequent State fiscal year to comply with federal law or regulations regarding hospital-specific payment limitations.~~
- g) ~~Definitions. Unless otherwise indicated, the following definitions apply to the terms used in this Section.~~
- ~~"Hospital" means any facility located in Illinois that is required to submit cost reports as mandated in Section 148.210.~~
- ~~"Large public hospital" means a county-owned hospital, as described in Section 148.25(b)(1)(A), a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), or a hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~
- ~~"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), for admissions occurring during State fiscal year 2005 as adjudicated by the Department through March 23, 2007.~~
- ~~"Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to Illinois recipients of medical assistance under Title XIX of the federal Social Security Act, assigned a diagnosis related group code of 370 through 375, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover day), for admissions occurring during State fiscal year 2005, as adjudicated by the Department through March 23, 2007.~~
- ~~"Outpatient Ambulatory Procedure Listing Payments" means, for a given hospital, the sum of payments for individuals covered under the Title XIX Medicaid State Plan, for its ambulatory procedure listing Group 3 services as described in Section 148.140(b)(1)(C), 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 assistance-base period that were adjudicated by the Department through March 23, 2007.~~

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- h) ~~Rate Reviews~~
~~Rate reviews shall be conducted in accordance with 89 Ill. Adm. Code 148.458(e)(2).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.464 General Provisions

Unless otherwise indicated, the following apply to Sections 148.466 through 148.486.

- a) For any children's hospital that did not charge for its services during the base period, the Department shall use data supplied by the hospital to determine payments using similar methodologies for freestanding children's hospitals under Sections 148.484 and 148.486.
- b) For purposes of this Section, a hospital that is enrolled to provide Medicaid services during State fiscal year 2009 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed.
- c) Payments
 - 1) For the period beginning June 10, 2012 through June 30, 2012, the annual payment on services will be prorated by multiplying the payment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days.
 - 2) Effective July 1, 2012, payments shall be paid in 12 equal installments on or before the 7th State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of these payment methodologies or any waiver required under 42 CFR 433.68, at which time the sum of amounts required prior to the date of notification is due and payable.
 - 3) Payments are not due and payable until these payment methodologies are approved by the federal Government and the assessment imposed under Section 5A-2(b-5) of the Public Aid Code, as implemented by 89 Ill. Adm. Code 140.80(b)(2), is determined to be a permissible tax under Title XIX of the Social Security Act.
 - 4) Accelerated Schedule. The Department may, when practicable, accelerate the schedule upon which payments authorized under Sections 148.466 through 148.486 are made.

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- 5) The Department may, in accordance with the IAPA, adjust payments under Sections 148.466 through 148.486 to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.
- 6) If the federal Centers for Medicare and Medicaid Services find that any federal Upper Payment Limit applicable to the payments under Sections 148.466 through 148.486 is exceeded, then the payments under Sections 148.466 through 148.486 that exceed the applicable federal Upper Payment Limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

d) Definitions

Unless the context requires otherwise or unless provided otherwise in Sections 148.466 through 148.486, the terms used in Section 148.484 for qualifying criteria and payment calculations shall have the same meanings as those terms are given in this Part as in effect on October 1, 2011. Other terms shall be defined as indicated in this subsection (d).

"Medicaid Days", "Ambulatory Procedure Listing Services" and "Ambulatory Procedure Listing Payments" do not include any days, charges or services for which Medicare or a Managed Care Organization reimbursed on a capitated basis was liable for payment, except as explicitly stated otherwise in Sections 148.466 through 148.486.

"Ambulatory Procedure Listing Services" means, for a given hospital, ambulatory procedure listing services, as described in Section 148.140(b), as was in effect on June 30, 2009, provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in State fiscal year 2009 that were adjudicated by the Department through September 2, 2010.

"Case Mix Index" means, for a given hospital, the sum of the per admission (DRG) relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal year 2009, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82 as was in effect on December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, divided by the total number of general acute care admissions for State fiscal year 2009, excluding Medicare crossover admissions and transplant admissions

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reimbursed under Section 148.82 as was in effect on December 31, 2013, as seen in <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>.

"Emergency Room Ratio" means, for a given hospital, a fraction, the denominator of which is the number of the hospital's outpatient ambulatory procedure listing and end-stage renal disease treatment services provided for State fiscal year 2009 and the numerator of which is the hospital's outpatient ambulatory procedure listing services for categories 3A, 3B and 3C for State fiscal year 2009.

"Estimated Medicaid Inpatient Days" means a percentage of actual inpatient Medicaid days to total inpatient days for the period July 1, 2011 to June 30, 2012, applied to total actual inpatient days for State fiscal year 2005.

"Estimated Medicaid Outpatient Services" means the percentage of actual outpatient Medicaid services to total outpatient services for the period of July 1, 2011 through June 30, 2012, applied to total actual outpatient services for State fiscal year 2005.

"Large Public Hospital" means ~~a county-owned hospital, as described in Section 148.25(a)(b)(1)(A), a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), or a hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~

"Medicaid Inpatient Day" means, for a given hospital, the sum of days of inpatient hospital 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 that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring during State fiscal year 2009 that were adjudicated by the Department through June 30, 2010.

"Medicaid General Acute Care Inpatient Day" means, a Medicaid inpatient day, as described in this subsection (d), for general acute care hospitals, and specifically excludes days provided in the hospital's psychiatric or rehabilitation units.

"Outpatient End-Stage Renal Disease Treatment Services" means, for a given hospital, the services, as described in Section 148.140 ~~(g)(e)~~, provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding payments 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 services occurring in State fiscal year 2009 that were adjudicated by the Department through September 2, 2010.

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e) Rate Reviews

- 1) A hospital shall be notified in writing of the results of the payment determination pursuant to Sections 148.466 through 148.486.
- 2) Hospitals shall have a right to appeal the calculation of their ineligibility for payments if the hospital believes that the Department has made a technical error. The appeal must be submitted in writing to the Department and must be received or postmarked within 30 days after the date of the Department's notice to the hospital of its qualification for the payment amounts, or a letter of notification that the hospital does not qualify for 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.

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f) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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Section 148.466 Magnet and Perinatal Hospital Adjustment Payments

- a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital qualifies for a Magnet and Perinatal Hospital Payment if it meets both of the following criteria:
 - 1) Was recognized as a "magnet hospital" by the American Nurses Credentialing Center as of August 25, 2011.
 - 2) Was designated a Level III Perinatal Center as of September 14, 2011.
- b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid general acute care inpatient days and:
 - 1) \$470 for hospitals with a case mix index equal to or greater than the 80th percentile of case mix indices for all Illinois hospitals.
 - 2) \$170 for all other hospitals.

c) This Section shall no longer be in effect as of January 1, 2015.

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(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.468 Trauma Level II Hospital Adjustment Payments

- a) **Qualifying Criteria.** With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the Trauma Level II Payment if it was designated as a Level II trauma center as of July 1, 2011.
- b) **Payment.** A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid general acute care inpatient days and:
 - 1) \$470, for hospitals with a case mix index equal to or greater than the 50th percentile of case mix indices for all Illinois hospitals.
 - 2) \$170, for all other hospitals.
- c) For the purposes of this adjustment, hospitals located in the same city that alternate their trauma center designation as defined in Section 148.295(a)(2) on December 31, 2013, as seen in, <http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, shall have the adjustment provided under this Section divided between the two hospitals.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.470 Dual Eligible Hospital Adjustment Payments

- a) **Qualifying Criteria.** With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the Dual Eligible Hospital Payment if it meets both of the following criteria:
 - 1) Has a ratio of crossover days to total inpatient days for programs administered by the Department under Title XIX of the Social Security Act (utilizing information from 2009 paid claims) that is greater than 50%.
 - 2) Has a case mix index equal to or greater than the 75th percentile of case mix indices for all Illinois hospitals.
- b) **Payment.** A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid inpatient days, including crossover days, and \$400.
- c) This Section shall no longer be in effect as of January 1, 2015.

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(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.472 Medicaid Volume Hospital Adjustment Payments

- a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the Medicaid Volume Hospital Payment if it meets all of the following criteria:
 - 1) Provided more than 10,000 Medicaid inpatient days of care;
 - 2) Has a Medicaid Inpatient Utilization Rate (MIUR) of at least 29.05%, for the rate year 2011 Disproportionate Share determination; and
 - 3) Is not eligible for Medicaid Percentage Adjustment (MPA) Payments for rate year 2011.
- b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid inpatient days and \$135.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.474 Outpatient Service Adjustment Payments

- a) Qualifying Criteria. With the exception of a large public hospital, Outpatient Service Adjustment Payments shall be paid to each Illinois hospital.
- b) Payment. A qualifying hospital shall receive an annual payment that is the product of \$100 and the hospital's outpatient Ambulatory Procedure Listing services (excluding categories 3B and 3C) and the hospital's outpatient end-stage renal disease treatment services.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.476 Ambulatory Service Adjustment Payments

- a) Qualifying Criteria. With the exception of a large public hospital, Ambulatory Service Adjustment Payments shall be paid to each Illinois hospital.

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- b) Payment. Qualifying hospitals shall receive an annual payment that is:
 - 1) For each Illinois freestanding psychiatric hospital, the product of \$200 and the hospital's Ambulatory Procedure Listing services for category 5A.
 - 2) For all other Illinois hospitals, the product of \$105 and the hospital's outpatient Ambulatory Procedure Listing services for categories 3A, 3B and 3C.
- c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.478 Specialty Hospital Adjustment Payments

- a) Qualifying Criteria. With the exception of a large public hospital, Specialty Hospital Payments shall be paid to an Illinois hospital that is one of the following:
 - 1) A Long Term Acute Care Hospital.
 - 2) A hospital devoted exclusively to the treatment of cancer.
- b) Payment. A qualifying hospital shall receive an annual payment that is the product of \$700 and the hospital's outpatient Ambulatory Procedure Listing services and the hospital's end-stage renal disease treatment services (including services provided to individuals eligible for both Medicaid and Medicare).
- c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.480 ER Safety Net Payments

- a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the ER Safety Net Payment if it meets all of the following criteria:
 - 1) Has an emergency room ratio equal to or greater than 55%;
 - 2) Was not eligible for Medicaid percentage adjustments payments in rate year 2011;

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- 3) Has a case mix index equal to or greater than the 20th percentile; and
 - 4) Was not designated as a trauma center by the Illinois Department of Public Health on July 1, 2011.
- b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Ambulatory Procedure Listing services and outpatient end-stage renal disease treatment services and:
- 1) \$225 for each hospital with an emergency room ratio equal to or greater than 74%.
 - 2) \$65 for all other hospitals.
- c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.482 Physician Supplemental Adjustment Payments

- a) Qualifying Criteria. With the exception of a large public hospital, physician services eligible for this Physician Supplemental Adjustment Payment are those provided by physicians employed by or who have a contract to provide services to patients of the following hospitals:
- 1) Illinois general acute care hospitals that:
 - A) Provided at least 17,000 Medicaid inpatient days of care in State fiscal year 2009; and
 - B) Was eligible for Medicaid Percentage Adjustment Payments in rate year 2011.
 - 2) Illinois freestanding children's hospitals, as defined in Section 148.2589 Ill. Adm. Code 149.50(e)(3)(A).
- b) Payment. A qualifying hospital shall receive an annual payment based upon a total pool of \$6,960,000. This pool shall be allocated among the eligible hospitals based on the following:
- 1) The difference between the upper payment limit for what could have been paid under Medicaid for physician services provided during State fiscal

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year 2009 by physicians employed by, or who had a contract with, the hospital, and the amount that was paid under Medicaid for those services.

- 2) In no event shall an individual hospital receive an annual, aggregate adjustment amount on physician services in excess of \$435,000, except that any amount that is not distributed to a hospital because of the upper payment limit shall be reallocated among the remaining eligible hospitals that are below the upper payment limit on a proportionate basis.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.484 Freestanding Children's Hospital Adjustment Payments

- a) **Qualifying Criteria.** With the exception of a large public hospital, an Illinois freestanding children's hospital that did not bill for services in 2005 shall qualify for the Freestanding Children's Hospital Adjustment Payments.
- b) **Payment.** A qualifying hospital shall receive an annual amount that is the product of the following:
 - 1) Estimated Medicaid inpatient days; and
 - 2) The quotient of the sum of the amounts calculated for children's hospitals at Section 148.442(b)(3) and (b)(6) and the Medicaid inpatient days for those same hospitals.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.486 Freestanding Children's Hospital Outpatient Adjustment Payments

- a) **Qualifying Criteria.** With the exception of a large public hospital, an Illinois freestanding children's hospital that did not bill for services in 2005 shall qualify for the Freestanding Children's Hospital Outpatient Payments.
- b) **Payment.** A qualifying hospital shall receive an annual amount that is the product of the following:

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- 1) Estimated Medicaid outpatient services reimbursed through methodologies described in Section 148.140(b)(1)(A) through (D); and
- 2) The quotient of the sum of the amounts calculated at Section 148.456(b)(2) and services provided during State fiscal year 2005 reimbursed through methodologies described in Section 148.140(b)(1)(A) through (D) for those same hospitals.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

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SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

Section 148.860 Community Connect IMD Hospital Payment

Effective for dates of service on or after July 1, 2014:

- a) The Community Connect IMD hospital in the demonstration program will be reimbursed on an incentive-driven basis. The Department will reimburse the initial claim for the psychiatric admission at 80% of the psychiatric hospital rate. The remainder of the full 100% of the psychiatric hospital rate will be paid if the individual remains stable in the community with no further psychiatric hospitalization for 45 days after the level of care assessment.
- b) Payment for any individual who cannot be discharged because the individual does not have a place to go and appropriate services cannot be implemented, but who is not an inpatient based on medical necessity, will be 50% of the alternate cost per diem rate as defined in ~~described in~~ Section 148.270 and 89 Ill. Adm. Code 152.200 on July 1, 2012.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.TABLE C List of Metropolitan Counties by SMSA Definition

"SMSA" means Standard State Metropolitan Statistical Area as defined by the U.S. Office of Management and Budget (OMB) Areas.

Boone	Champaign	Clinton	Cook	DuPage
Henry	Kane	Kankakee Lake	Lake Macon	Macon Madison
Madison McHenry	McHenry McLean	McLean Menard	Menard Monroe	Monroe Peoria
Peoria Rock Island	Rock	Sangamon St.	St.	Tazewell Will

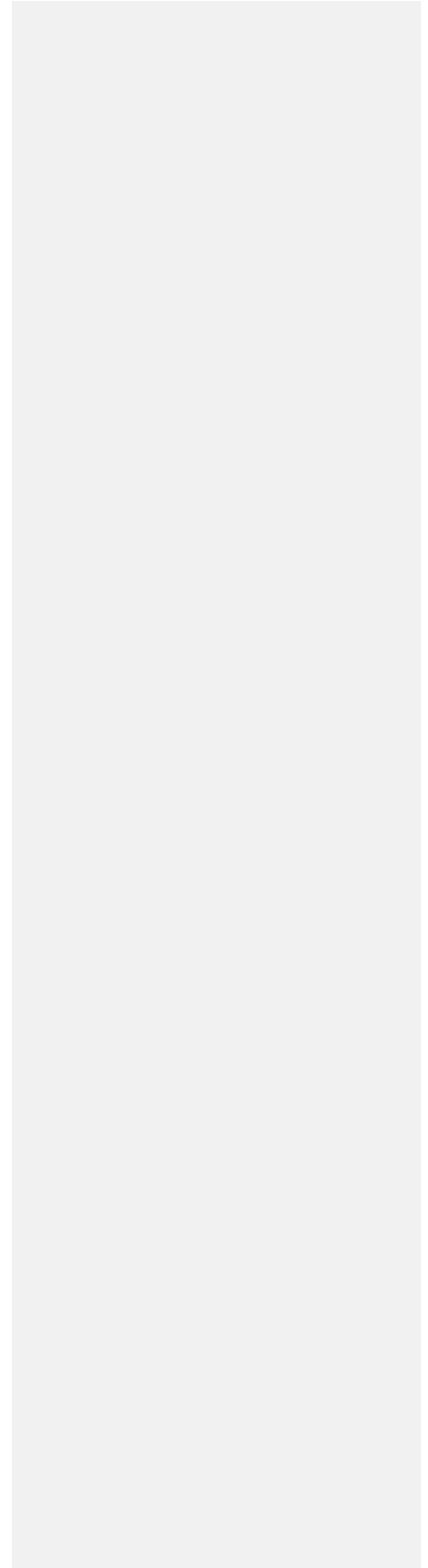
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~~Will~~ Winnebago ~~Island~~ Sangamon ~~Clair~~ Clair ~~Tazewell~~
~~Winnebago~~ Winnebago ~~Woodford~~ Woodford

(Source: Amended at 38 Ill. Reg. _____, effective _____)



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- 1) Heading of the Part: Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
- 2) Code Citation: 89 Ill. Adm. Code 149
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
149.5	Repeal
149.10	Amendment
149.25	Amendment
149.50	Amendment
149.75	Amendment
149.100	Amendment
149.105	Amendment
149.125	Repeal
149.150	Repeal
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11].
- 5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.
- 12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed

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Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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

217/782-1233

HFS.Rules@illinois.gov.

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
 - B) Reporting, bookkeeping or other procedures required for compliance: None
 - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this Rulemaking was Summarized: January 2014

The full text of the Proposed Amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 149

DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS)

Section

- 149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
(Repealed)
- 149.10 Applicability of Other Provisions
- 149.25 General Provisions
- 149.50 Hospital Inpatient Services Subject to and Excluded from the DRG Prospective Payment System
- 149.75 Conditions for Payment Under the DRG Prospective Payment System
- 149.100 Basic Methodology for Determining DRG PPS Prospective Payment Rates
- 149.105 Payment For Outlier Cases
- 149.125 Special Treatment of Certain Facilities (Repealed)
- 149.150 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)
- 149.150 Payments to Hospitals Under the DRG Prospective Payment System
- 149.175 Payments to Contracting Hospitals (Repealed)
- 149.200 Admitting and Clinical Privileges (Repealed)
- 149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed)
- 149.225 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)
- 149.250 Contract Monitoring (Repealed)
- 149.275 Transfer of Recipients (Repealed)
- 149.300 Validity of Contracts (Repealed)
- 149.305 Termination of ICARE Contracts (Repealed)
- 149.325 Hospital Services Procurement Advisory Board (Repealed)
- 149.326 SMART Hospital Payment Reform

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI, VII and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.940 through 140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 12095, effective July 15, 1988; amended at 13 Ill. Reg. 554, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill.

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Reg. 1826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11937, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14733, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19868, effective December 7, 1992; amended at 17 Ill. Reg. 3217, effective March 1, 1993; emergency amendment at 17 Ill. Reg. 17275, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3378, effective February 25, 1994; amended at 19 Ill. Reg. 10674, effective July 1, 1995; amended at 21 Ill. Reg. 2238, effective February 3, 1997; emergency amendment at 22 Ill. Reg. 13064, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19866, effective October 30, 1998; amended at 25 Ill. Reg. 8775, effective July 1, 2001; amended at 26 Ill. Reg. 13676, effective September 3, 2002; emergency amendment at 27 Ill. Reg. 11080, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18872, effective November 26, 2003; amended at 28 Ill. Reg. 2836, effective February 1, 2004; amended at 38 Ill. Reg. _____, effective _____.

**Section 149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
(Repealed)**

a)– Sections 149.25 through 149.150 describe:

- 1) ~~The basis of payment for inpatient hospital services under the DRG PPS and set forth the general basis for the system;~~
- 2) ~~Classifications of hospitals that are included and excluded from the DRG PPS and the requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification;~~
- 3) ~~Conditions that must be met for a hospital to receive payment under the DRG PPS;~~
- 4) ~~The methodology by which DRG prospective rates are determined;~~
- 5) ~~The methodology for determining additional payments for outlier cases;~~
- 6) ~~The rules for special treatment of certain facilities; and~~
- 7) ~~The types, amounts and methods of payment to hospitals under the DRG PPS.~~

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- b) ~~Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:~~
- 1) ~~Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under Part 149.~~
 - 2) ~~Exceptions. The provisions of subsection (b)(1) above shall not apply to:~~
 - A) ~~Hospitals reimbursed under 89 Ill. Adm. Code 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.82, 148.160, or 148.170, as applicable.~~
 - B) ~~Hospitals reclassified as rural hospitals as described in 89 Ill. Adm. Code 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.40(f)(4) and 148.260, or Section 149.100(e)(1)(A), whichever is applicable.~~
 - C) ~~The inpatient payment adjustments described in 89 Ill. Adm. Code 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with 89 Ill. Adm. Code 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.~~
- e) ~~Definitions~~
~~Unless specifically stated otherwise, the definitions of terms used in this Part are as follows:~~
- 1) ~~"DRG grouper" means:~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare DRG grouper in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).~~

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- B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare DRG grouper which is in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).~~
- 2) "Medicare weighting factor" means:
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Medicare DRG weighting factors in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).~~
 - B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Medicare DRG weighting factors in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).~~
- 3) "PPS Pricer" means:
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare PPS Pricer, Version 92.0.~~
 - B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare PPS Pricer version that is in effect 90 days prior to the date of admission.~~
- 4) "Marginal Cost Factor":
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the marginal cost factor shall be the same as that employed by Medicare on September 1, 1992.~~
 - B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the marginal cost factor shall be the same as that employed by Medicare 90 days prior to the date of admission.~~
- 5) "Cost Outlier Threshold":

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- A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the cost outlier threshold shall be the same as that employed by Medicare on September 1, 1992, adjusted for the differences in Medicare and Medicaid policies and population, as described in Section 149.100(a)(1).~~
- B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the cost outlier threshold/fixed loss threshold shall be the same as that employed by Medicare 90 days prior to the date of admission.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 149.10 Applicability of Other Provisions

~~Effective for dates of service on or after July 1, 2014, the~~ The following provisions, in addition to those provisions specifically cited in this Part, shall apply to hospitals reimbursed under the Diagnosis Related Grouping Prospective Payment System (DRG PPS):

- a) ~~The general requirements applicable to all hospital services, as described in General Provisions of 89 Ill. Adm. Code Part 148, Subpart A. Participation, as described in 89 Ill. Adm. Code 148.20.~~
- b) ~~Organ transplant services, as described in 89 Ill. Adm. Code 148.82. Definitions and Applicability, as described in 89 Ill. Adm. Code 148.25.~~
- e) ~~General requirements, as described in 89 Ill. Adm. Code 148.30.~~
- d) ~~Special requirements, as described in 89 Ill. Adm. Code 148.40.~~
- e) ~~Covered hospital services, as described in 89 Ill. Adm. Code 148.50.~~
- f) ~~Services not covered as hospital services, as described in 89 Ill. Adm. Code 148.60.~~
- g) ~~Limitations on hospital services, as described in 89 Ill. Adm. Code 148.70.~~
- ch) Hospital outpatient and hospital-based clinic services, as described in 89 Ill. Adm. Code 148.140.

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- ~~d~~i) Payment for pre-operative days ~~and~~; patient specific orders, ~~and services which can be performed in an outpatient setting~~, as described in 89 Ill. Adm. Code 148.180.
- ~~e~~j) Copayments, as described in 89 Ill. Adm. Code 148.190.
- ~~f~~k) Filing cost reports, as described in 89 Ill. Adm. Code 148.210.
- ~~g~~l) Review procedure, as described in 89 Ill. Adm. Code 148.310.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.25 General Provisions

Effective for dates of service on or after July 1, 2014:

- a) Basis of Payment
 - 1) Payment on a Per Discharge Basis
 - A) Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
 - B) The DRG prospective payment rate for each discharge (as defined in subsection (b) below) is determined according to the methodology described in Sections 149.100 and 149.150, as appropriate. An additional payment is made, in accordance with Sections 149.105 and 149.125, as appropriate. The rates paid shall be those in effect on the date of admission.
 - 2) Payment in Full
 - A) The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs (as described in subsection (a)(3) below) incurred in furnishing services covered under the Medicaid Program.

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- B) Except as provided for in subsection (g) of 149.100, ~~(b) below~~, the full DRG prospective payment amount, as determined under Sections 149.100 ~~and 149.150, as appropriate~~, is made for each inpatient stay ~~during which there is at least one Medicaid-eligible day of care.~~
- 3) ~~Inpatient-Operating Costs.~~ The DRG-PPS provides a payment amount for ~~inpatient operating costs, including:~~
- A) ~~Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;~~
 - B) ~~Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;~~
 - C) ~~Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990);~~
 - D) ~~Malpractice insurance costs related to services furnished to inpatients; and~~
 - E) ~~Hospital-based physician costs as described in Section 149.75(h)(1)(A).~~
- 4) ~~Excluded Costs/Services.~~ The following inpatient hospital costs are excluded from the DRG prospective payment amounts:
- A) ~~Transplantation cost, including acquisition cost incurred by approved transplantation centers as described in 89 Ill. Adm. Code 148.82. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Sections 149.100 and 149.150 or in 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~
 - B) ~~Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21).~~

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~~Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).~~

- ~~C) Costs of nonemergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.~~
- ~~D) Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRGs 424-432). Such services exceeding the maximum of three days shall not be eligible for reimbursement.~~
- ~~E) Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).~~
- ~~F) Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall be reimbursed under 89 Ill. Adm. Code 148.340 through 148.390.~~
- 5) Additional Payments to Hospitals. In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:
 - ~~A) Atypically long or extraordinary costly (outlier) cases, as described in Section 149.105.~~
 - ~~B) Certain costs excluded from the prospective payment rate under subsection (a)(4) above.~~
 - ~~C) The cost of serving a disproportionately high share of low income patients (as defined and determined in Section 149.125(a)(2)).~~
 - ~~D) Specific inpatient payment adjustments (as defined and determined in Section 149.125(a)(3)).~~

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b) ~~Discharges and Transfers~~

1) ~~Discharges. A hospital inpatient is considered discharged when any of the following occurs:~~

~~A) The patient is formally released from the hospital except when the patient is transferred to another hospital or a distinct part unit as described in Section 149.50(d) (see subsection (b)(2) below);~~

~~B) The patient dies in the hospital.~~

2) ~~Transfers. A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Section 149.50(d).~~

3) ~~Payment in Full to the Discharging Hospital. The hospital discharging an inpatient (subsection (b)(1)(A) above) is paid in full, in accordance with subsection (a)(2) above unless the discharging hospital or distinct part unit is excluded from the DRG PPS as described in Section 149.50(b), (c) and (d). In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~

4) ~~Payment to a Hospital Transferring an Inpatient to Another Hospital or District Part Unit~~

~~A) A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in subsection (b)(2), is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Section 149.100 if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Section 149.100) by the geometric length of stay for the specific DRG to which the case is classified.~~

~~B) Except, if a discharge is classified into DRGs 385 or 985 (neonates, died or transferred to another acute care facility) or~~

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~~DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with subsection (a)(2).~~

~~C) A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Section 149.105.~~

~~D) A hospital or distinct part unit excluded from the DRG PPS, as described in Section 149.50(b), (c) or (d), that transfers an inpatient under the circumstances described in subsection (b)(2) of this Section, is reimbursed in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~

~~e) Admission Prior to September 1, 1991. With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991, for each covered day of care provided through the discharge of the patient.~~

~~d) DRG Classification System~~

~~1) The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), modified to handle additional DRGs and revised ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.~~

~~2) The Department will define additional DRGs that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.50 Hospital **Inpatient** Services Subject to and Excluded from the DRG Prospective Payment System

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Effective for dates of service on or after July 1, 2014:

- a) Inpatient services subject to submission for DRG grouping. All hospital inpatient services provided to enrollees of the Medical Assistance programs, without regard to balance due or expected reimbursement methodology to be applied by the Department, must be documented on a claim and submitted to the Department. The Department shall process and group all hospital inpatient claims through the DRG grouper. Hospital Services Subject to the DRG Prospective Payment System
- 1) ~~Except for services described in Section 149.25(a)(4) and subsection (b)(2) below, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.~~
- 2) ~~Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:~~
- A) ~~The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under subsections (c) through (d) below.~~
- B) ~~The services are furnished by a nonparticipating out-of-state hospital (as described in subsection (c)(5) below).~~
- C) ~~The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in subsection (c)(6) below) in the transition period of DRG PPS implementation.~~
- D) ~~The services are furnished by a sole community hospital (as defined in Section 149.125(b)) that has elected to be exempted from the DRG PPS in accordance with subsection (c)(7) below.~~
- E) ~~The payment for services is covered by a health maintenance organization (HMO).~~
- b) Excluded from DRG PPS reimbursements are: ~~and Exempted Hospitals and Hospital Units: General Rules~~

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- 1) ~~Psychiatric services provided by: Criteria. A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the classifications described in subsection (c) below:~~
 - A) ~~A psychiatric hospital, as described in 89 Ill. Adm. Code 148.25(d)(1).~~
 - B) ~~A distinct part psychiatric unit, as described in 89 Ill. Adm. Code 148.25(c)(1).~~

- 2) ~~Physical rehabilitation services provided by: Alternate Reimbursement System. All excluded hospitals (and excluded distinct part hospital units, as described in subsection (d) below) are reimbursed under the Alternate Reimbursement Systems set forth in 89 Ill. Adm. Code 148.250 through 148.300 with the exception of those hospitals described in subsection (e)(8) below. The hospitals described in subsection (e)(8) below are reimbursed in accordance with 89 Ill. Adm. Code 148.160 or 148.170, as appropriate.~~
 - A) ~~A rehabilitation hospital, as described in 89 Ill. Adm. Code 148.25(d)(2).~~
 - B) ~~A distinct part rehabilitation unit, as described in 89 Ill. Adm. Code 148.25(c)(2).~~

- 3) ~~Services provided by a long term acute care hospital, as described in 89 Ill. Adm. Code 148.25(d)(4), that are not psychiatric services or services described in subsections (b)(6) through (b)(7) of this Section.~~

- 4) ~~Inpatient services, reimbursed pursuant to 89 Ill. Adm. Code 148.330.~~

- 5) ~~Services provided by a large public hospital, as described in 89 Ill. Adm. Code 148.25(a).~~

- 6) ~~Hospital residing long term care services, as described in 89 Ill. Adm. Code 148.50(c).~~

- 7) ~~Sub-acute alcoholism and substance abuse treatment services, as defined in 77 Ill. Adm. Code 2090.40.~~

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- 8) Inpatient services provided by Children's Specialty Hospitals as described in 89 Ill. Adm. 148.116.
- e) ~~Excluded Hospitals.—Classifications.—Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.~~
- 1) ~~Psychiatric Hospitals.—A psychiatric hospital must:~~
- A) ~~Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and~~
- B) ~~Be enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program.~~
- 2) ~~Rehabilitation Hospitals.—A rehabilitation hospital must:~~
- A) ~~Hold a valid license as a physical rehabilitation hospital; and~~
- B) ~~Be enrolled with the Department as a rehabilitation hospital to provide inpatient rehabilitation services (category of service 22) and have a Provider Agreement to participate in the Medicaid Program.~~
- 3) ~~Children's Hospitals.—To qualify as a children's hospital, the facility must have a Provider Agreement to participate in the Medicaid program and be either:~~
- A) ~~A hospital devoted exclusively to caring for children; or~~
- B) ~~A general care hospital which includes a facility devoted exclusively to caring for children that meets one of the following definitions:~~
- i) ~~A facility that is separately licensed as a hospital by a municipality prior to September 30, 1998. Such hospitals shall be reimbursed for all inpatient and outpatient services~~

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~~rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered; or~~

- ii) ~~A facility that has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization Rate, as defined at 89 Ill. Adm. Code 148.12(k)(5), greater than 55 percent for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days. Qualified children days means the number of hospital inpatient days for recipients under 18 years of age who are eligible under Medicaid, excluding days for normal newborn, obstetrical, psychiatric, Medicare crossover, and rehabilitation services, as determined from the Department's claims data for days occurring in State fiscal year 2001 that were adjudicated by the Department through June 30, 2002. Such hospitals shall be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered.~~

4) ~~Long Term Stay Hospitals. A long term stay hospital must:~~

- A) ~~Not be a psychiatric hospital, as described in subsection (c)(1) above, a rehabilitation hospital as described in subsection (c)(2) above, or a children's hospital as described in subsection (c)(3) above and must have an average length of inpatient stay greater than 25 days: as computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the most recent State fiscal year for which complete information is available; and~~
- B) ~~Have a Provider Agreement to participate in the Medicaid Program.~~

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- 5) ~~Hospitals Outside of Illinois that are Exempt from Cost Reporting Requirements.~~ A hospital is excluded from the DRG PPS if it meets the following definition: a nonparticipating out-of-state hospital is an out-of-state hospital that provides fewer than 100 Illinois Medicaid days annually, that does not elect to be reimbursed under this Part (the DRG Prospective Payment System), and that does not file an Illinois Medicaid cost report.
 - 6) ~~Hospitals Reimbursed Under Special Arrangements.~~ Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).
 - 7) ~~Sole Community Hospitals.~~ Hospitals described in Section 149.125(b), which have elected to be exempted from the DRG PPS, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).
 - 8) ~~County-Owned Hospitals and Hospitals Organized Under the University of Illinois Hospital Act.~~ County-owned hospitals located in an Illinois county with a population greater than three million and hospitals organized under the University of Illinois Hospital Act are excluded from the DRG system and are reimbursed under unique hospital-specific reimbursement methodologies as described in 89 Ill. Adm. Code 148.160 and 148.170.
- e) ~~Excluded Distinct Part Hospital Units~~
- 1) ~~Distinct Part Psychiatric Units.~~ With the exception of those hospitals described in subsections (e)(1) through (e)(8) above, a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).
 - 2) ~~Distinct Part Rehabilitation Units.~~ With the exception of those hospitals described in subsections (e)(1) through (e)(8) above, a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement

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~~of such inpatient rehabilitation services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.75 Conditions for Payment Under the DRG Prospective Payment System

Effective for dates of service on or after July 1, 2014:

a) General Requirements

- 1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
- 2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medical Assistance~~Medicaid~~ clients, the Department may, as appropriate:
 - A) Withhold ~~Medicaid~~ payments (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
 - B) Terminate the hospital's Provider Agreement pursuant to 89 Ill. Adm. Code 140.16.

- b) Hospital Utilization Control. Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medical Assistance~~Medicaid~~ as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456 (October 1, ~~2013~~¹⁹⁹⁹). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 148.25(d)(1)~~Section 149.50(e)(1)~~, shall be in accordance with federal regulations.

- c) Medical Review Requirements: Admissions and Quality Review
Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (~~PRO~~) shall review, on an ongoing basis, the following:

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- 1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.
 - 2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.
 - 3) The validity of the hospital's diagnostic and procedural information.
 - 4) The completeness, adequacy and quality of the services furnished in the hospital.
 - 5) Other medical or other practice with respect to program participants or billing for services furnished to program participants.
- d) Medical Review Requirements: DRG Validation. The Department, or its agent, may require and perform pre-or-post-payment review of diagnosis and procedure codes to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records. The review may be undertaken by way of a sample of discharges. The review may, at the sole discretion of the Department, take place at the hospital or away from the hospital site.
- 4) ~~Coding attestation. Beginning with admissions on or after March 1, 1997, and ending with admissions on or after July 1, 2001, the Health Information Management Director (Medical Records) or his or her designee(s) within the Health Information Management Department must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal and secondary diagnoses, and major procedures as indicated in the medical record. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the signature of the Health Information Management Director or his or her designee(s) within this Department: "I certify that the ICD-9-CM coding of principal and secondary diagnoses and the major procedures performed are accurate and complete based on the contents of the medical record, to the best of my knowledge." The name of the person signing the attestation must be typed or clearly printed and appear on the same page as the signature.~~

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- 2) ~~DRG Validation. The Department, or its designated peer review organization, may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.~~
- 3) ~~Sample Reviews~~
 - A) ~~The Department, or its designated peer review organization, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.~~
 - B) ~~Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.~~
- 4) ~~Revision of Coding~~
 - A) ~~If the diagnostic and procedural information, in compliance with the coding attestation requirements in subsection (d)(1) of this Section, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.~~
 - B) ~~If the information, in compliance with the coding attestation requirements in subsection (d)(1) of this Section, is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.~~
- e) Utilization Review Requirements: The Department, or its designated peer review organization (~~see as described in~~ 89 Ill. Adm. Code 148.240(j)), may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews, as defined at 89 Ill. Adm. Code 148.240.
- f) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

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- 1) The ~~applicable~~ payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (f)(1)(B)(~~i~~) through (~~v~~) of this Section.
 - A) Hospital-based physicians who may not bill separately on a fee-for-service basis
 - i) A physician whose salary is included in the hospital's cost report for direct patient care ~~may not bill separately on a fee for service basis.~~
 - ii) A teaching physician who provides direct patient care, ~~may not bill separately on a fee for service basis~~ if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.
 - B) Hospital-based physicians who may bill separately on a fee-for-service basis
 - i) A physician whose salary is not included in the hospital's cost report for direct patient ~~care may bill separately on a fee for service basis.~~
 - ii) A teaching physician who provides direct patient care, ~~may bill separately on a fee for service basis~~ if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.
 - iii) A resident ~~may bill separately on a fee for service basis~~ when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.
 - iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, ~~may bill separately on a fee for service basis~~ when, by the terms of his or her contract with the hospital, he or

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she may charge for professional services and ~~does~~, in fact, bill private patients and collect and retain the payments received.

- v) A physician holding a nonteaching administrative or staff position in a hospital or medical school, ~~but only may bill separately on a fee for service basis~~ to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

- 2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.100 ~~Basic~~ Methodology for Determining DRG PPS ~~Prospective~~ Payment Rates

Effective for dates of service on or after July 1, 2014:

- a) Inpatient hospital services that are not excluded from the DRG PPS pursuant to Section 149.50(b) shall be reimbursed as determined in this Section.
- b) Total DRG PPS payment. Under the DRG PPS, services to inpatient who are:
 - 1) Discharges shall be paid pursuant to subsection (c).
 - 2) Transfers shall be paid pursuant to subsection (g)
 - 3) The total payment for an inpatient stay will equal the sum of the payment determined in subsection (c) or (g), as applicable, and any applicable adjustments to payment specified in 89 Ill. Adm. Code 148.290.
- c) DRG PPS payment for discharges. The reimbursement to hospitals for inpatient services based on discharges shall be the product, rounded to the nearest hundredth, of the following:

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- 1) The greater of:
 - A) 1.0000, or
 - B) highest policy adjustment factor, as defined in subsection (f), for which the inpatient stay qualifies.
 - 2) The sum of the DRG base payment, as defined in subsection (d), and any applicable outlier adjustment, as determined in Section 149.105, for which the claim qualifies.
- d) The DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:
- 1) The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the DRG grouper.
 - 2) The DRG base rate, equal to the sum of:
 - A) The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare IPPS wage index, the statewide standardized amount and the GME factor.
 - B) The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the statewide standardized amount and the GME factor.
- e) Medicare IPPS wage index. Medicare IPPS wage index is determined based on:
- 1) For Medicare IPPS hospitals, the wage index is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system hospital post-reclass wage index effective October 1, 2012.
 - 2) For non-Medicare IPPS hospitals and non-cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system

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wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective October 1, 2012.

f) Policy adjustments. Claims for inpatient stays that meet certain criteria may qualify for further adjustments to payment.

1) Transplantation services.

A) Policy adjustment factor: 2.11.

B) Qualifying criteria.

i) The hospital meets all requirements to perform transplantation services, including but not limited to those detailed in 89 Ill. Adm. Code 148.82.

ii) The claim has been grouped to one of the following DRGs:

- 001 Liver transplant.
- 002 heart and/or lung transplant.
- 003 Bone marrow transplant.
- 006 Pancreas transplant.
- 440 Kidney transplant.

2) Trauma services.

A) Policy adjustment factor:

i) 2.9100, if the hospital is a level I trauma center.

ii) 2.7600, if the hospital is a level II trauma center.

B) Criteria:

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- i) Hospital is recognized by the Department of Public Health as a level I or II trauma center on the date of admission.
- ii) The claim has been grouped to one of the following DRGs:
 - 020 Craniotomy for trauma
 - 055 Head trauma, with coma lasting more than on one hour or no coma.
 - 056 Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.
 - 057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.
 - 135 Major chest and respiratory trauma.
 - 308 Hip and femur procedures for trauma, except joint replacement.
 - 384 Contusion, open wound and other trauma to skin and subcutaneous tissue.
 - 910 Craniotomy for multiple significant trauma.
 - 911 Extensive abdominal/thoracic procedures for multiples significant trauma.
 - 912 Musculoskeletal and other procedures for multiple significant trauma.
 - 930 Multiple significant trauma, without operating room procedure.
- 3) Perinatal services.
 - A) Policy adjustment factor:
 - i) 1.3500, if the DRG to which the claim is grouped has an SOI of 1.
 - ii) 1.4300, if the DRG to which the claim is group has an SOI of 2.
 - iii) 1.4100, if the DRG to which the claim is grouped has an SOI of 3.

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iv) 1.5400, if the DRG to which the claim is grouped has an SOI of 4.

B) Criteria:

i) Hospital was recognized by the Department of Public Health as a level III perinatal center on the date of admission.

ii) The claim has been grouped to one of the following MDCs:

14 Pregnancy, childbirth and puerperium

15 Newborn and other neonates.

g) DRG PPS payment for transfers. The reimbursement to hospitals for inpatient services provided to transfers shall be lesser or:

1) The amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge.

2) The product, rounded to the nearest hundredth, of the following:

A) The quotient resulting from dividing the amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge by the DRG average length of stay for the DRG to which the inpatient claim has been assigned.

B) The length of stay plus the constant 1.0.

h) Updates to DRG PPS reimbursement. The Department may annually review the components as listed in subsection (c) and make adjustments as needed.

i) Definitions.

“Allocated static payments” means the adjustment payments made to the hospital pursuant to 89 Ill. Adm. Code 148.85 through 148.117 and 148.295 through 148.297 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies as outlined in:

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<http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx>, as determined by the Department, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

“Discharge” means a hospital inpatient that (i) has been formally released from the hospital, except when the patient is a transfer or (ii) died in the hospital.

“DRG” means diagnosis related group, as defined in the DRG grouper, based the principal diagnosis, surgical procedure used, age of patient, etc.

“DRG average length of stay” means, for each DRG and SOI combination, the national arithmetic mean length of stay for that combination rounded to the nearest tenth, as published by 3M Health Information Systems for the DRG grouper.

“DRG grouper” means the most recently released version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, DRG grouper means the version 30 of the APR-DRG software.

“DRG PPS” means the DRG prospective payment system as described in this Part.

“DRG weighting factor” means, for each DRG and SOI combination shall equal the product, rounded to the nearest ten-thousandth, of the national weighting factor for that combination, as published by 3M Health Information Systems for the DRG grouper, and the Illinois experience adjustment.

“GME factor” means the Graduate Medical Education factor applied to major teaching hospitals determined such that simulated payments under the new inpatient system with GME factor adjustments are \$3 million greater than simulated payments under the new inpatient system without GME factor adjustments, using inpatient base period paid claims data.

“Illinois experience adjustment” means for the calendar year beginning January 1, 2014, a quotient, computed by dividing the constant 1.0000 by the arithmetic

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mean 3M APR-DRG national weighting factors of claims for inpatient stays subject to reimbursement under the DRG PPS using inpatient base period paid claims data, rounded to the nearest ten-thousandth; for subsequent calendar years, means the factor applied to 3M APR-DRG national weighting factors, when updating DRG grouper versions determined such that the arithmetic mean DRG weighting factor under the new DRG grouper version is equal to the arithmetic mean DRG weighting factor under the prior DRG grouper version using inpatient base period claims data.

“Inpatient base period claims data” means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for DRG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, the most recently available adjudicated 12 months of inpatient paid claims data to be identified by the Department.

“Inpatient stay” means a formal admission into a hospital, pursuant to the order of a licensed practitioner permitted by the state in which the hospital is located to admit patients to a hospital that requires at least one overnight stay.

“Length of stay” means the number of days the patient was an inpatient in the hospital; with the day of the patient became a discharge or transfer not counting toward the length of stay.

“Medical assistance” means one of the programs administered by the Department that provides health care coverage to Illinois residents.

“Medicare CBSA” means the Core-Based Statistical Areas for a hospital’s location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

“Medicare IPPS labor share percentage” means the Medicare inpatient prospective payment system operating standardized amount labor share percentage for the federal fiscal year ending three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the labor share percentage in the Medicare inpatient prospective payment system for the federal fiscal year beginning October 1, 2012, which is 0.6880 for a hospital with a Medicare IPPS wage index greater 1.0 or 0.6200 for all other hospitals.

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“Medicare IPPS non-labor share” means the difference of 1.0 and the Medicare IPPS labor share percentage.

“MDC” means major diagnostic category – group of similar DRGs, such as all those affecting a given organ system of the body.

“SOI” means one of four subclasses of each DRG, as published by 3M Health Information Systems for the DRG grouper that relate to severity of illness (the extent of physiologic de-compensation or organ system loss of function experience by the patient) and risk of (the likelihood of) dying.

“Statewide standardized amount” means the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS payments, without SMART Act reductions or GME factor adjustments, using general acute hospital inpatient based period paid claims data, are \$355 million less than the sum of inpatient based period paid claims data reported payments and allocated inpatient static payments.

“Transfer” means a hospital inpatient that has been placed in the care of another hospital except that a transfer does not include an inpatient claim that has been assigned to DRG 580 (Neonate, transferred, less than five days old, not born here) or 581 (Neonate, transferred, less than five days old, born here).

~~a) DRG Classification and Weighting Factors~~

~~1) DRG Classification. The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), to classify inpatient hospital discharges by diagnosis related groups (DRGs) as defined by federal regulation for the Medicare Program (42 CFR 412), with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.~~

~~2) DRG Weighting Factors~~

~~A) Except as provided in subsections (a)(2)(B) through (a)(2)(E) below, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor, as described in Section 149.5(c)(2), for that group, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the~~

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~~denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:~~

~~i) Use the Medicare geometric mean length of stay for each diagnostic related group as determined by the Health Care Financing Administration of the United States Department of Health and Human Services.~~

~~ii) Calculate the Medicaid geometric mean length of stay for each diagnostic related group using the same methodology employed to calculate the Medicare geometric mean length of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases.~~

~~B) The Illinois weighting factors for neonatal discharges (Medicare-defined DRGs 385-391 and Illinois-defined DRGs for Level III perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.~~

~~i) Mean cost per discharge, for any DRG, is defined as the sum of the product of charges, as reported by a hospital on claims paid by the Department, less costs for capital, direct and indirect medical education, updated to the current rate year using the national hospital market basket price proxies (DMI) and the hospital's cost to charge ratio, as derived from the hospital's most recent audited cost report divided by the number of discharges for that DRG.~~

~~ii) Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).~~

~~C) The Illinois weighting factors for psychiatric discharges (DRGs 424-432) shall be computed as specified in subsections (a)(1) and (a)(2) except, prior to computing the Medicaid geometric mean~~

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~~length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.~~

D) ~~The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 436, alcohol/drug dependence with rehabilitation therapy; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 481, bone marrow transplant; DRG 495, lung transplant.~~

E) ~~Except for DRGs otherwise specified in subsections (a)(2)(B) through (a)(2)(D), the Illinois weighting factors for DRGs for which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.~~

i) ~~For rate periods beginning on or after October 1, 1992, for those DRGs with 32 or more records available, the Illinois weighting factor shall be set at the midpoint between the weight calculated using the methodology in subsection (a)(2)(A) and the Medicare weighting factor, as described in Section 149.5(e)(2).~~

ii) ~~For those DRGs with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor, as described in Section 149.5(e)(2).~~

3) ~~Assignment of Discharges to DRGs. The Department will establish a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.~~

A) ~~The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.~~

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- B) ~~Each discharge will be assigned to only one DRG (related, except as provided in subsection (a)(3)(C), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.~~
- C) ~~When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Department's DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the unrelated diagnosis and procedure are confirmed.~~
- 4) **Review of DRG Assignment**
 - A) ~~A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.~~
 - B) ~~The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Department's peer review organization to review the case to verify the change in DRG assignment.~~
 -
 - C) ~~Following the 60-day period described in subsection (a)(4)(A) above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.~~
- b) **Illinois Rates for Admission**
 - 4) ~~Reimbursement to hospitals for claims for admissions occurring prior to October 1, 1992, shall be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The payments described in Sections 149.5 through 149.150 and 89 Ill. Adm. Code 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to 89 Ill. Adm. Code 148.20(b) and Section 149.5(b).~~

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- ~~2) The payments described in 89 Ill. Adm. Code 148.82 shall be effective for services provided on or after July 1, 1992.~~
- e) ~~Determining Prospective Payment Rates~~
 - 1) ~~Federal/Regional Blended Rate Per Discharge~~
 - A) ~~Except as specified in subsection (c)(1)(B) below, the Department shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in subsection (c)(2) below, if applicable, and as computed by the PPS Pricer, as described in Section 149.5(c)(3).~~
 - B) ~~In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), on July 15, 1993:~~
 - i) ~~Effective with admissions occurring on October 1, 1993, and for the duration of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Department shall recompute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect on September 1, 1992, under the Medicare Program.~~
 - ii) ~~Effective with admissions occurring on or after the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall compute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect 90 days prior to the date of admission, under the Medicare Program.~~
 - 2) ~~Hospital Specific Portion~~
~~The hospital specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole~~

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~~community hospitals, rural referral centers and Medicare dependent hospitals, and rural hospitals deemed urban.~~

- 3) ~~DRG PPS Base Rate~~
~~The DRG PPS base rate shall be defined as the sum of the amounts computed under subsections (c)(1) and (c)(2), multiplied by the Illinois weighting factor assigned to the DRG into which the case has been classified.~~
- 4) ~~Payment Adjustments~~
~~In addition to the DRG PPS base rate defined in subsection (c)(3), hospitals shall receive applicable outlier adjustments, in accordance with Section 149.105; applicable adjustments for capital costs in accordance with Section 149.150(e); applicable adjustments for disproportionate share, in accordance with 89 Ill. Adm. Code 148.120; applicable adjustments for uncompensated care, in accordance with 89 Ill. Adm. Code 148.150; various specific inpatient payment adjustments, as applicable, in accordance with 89 Ill. Adm. Code 148.290.~~
- d) ~~Application of Upper Payment Limits. The Department shall adjust each of the prospective payment rates determined under subsection (c) above (with the exception of disproportionate share payment adjustments made in accordance with 89 Ill. Adm. Code 148.120) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.105 Payment For Outlier Cases

Effective for dates of service on or after July 1, 2014:

- a) Outlier adjustment determination. Except as provided in subsection (b), the Department may provide for additional payment, approximating a hospital's marginal cost of covered inpatient hospital services beyond thresholds specified by the Department. To qualify for such payment, the claim must meet the following criteria:
~~General Provisions~~

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- 1) ~~The services on the claim must be reimbursable under the DRG PPS. Except as provided in subsections (a)(3) and (a)(4) of this Section, the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the conditions in the following subsections (A) or (B) apply. The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the threshold is set at the lesser of the geometric mean length of stay plus 27 days, or the geometric mean length of stay plus three standard deviations.~~
 - B) ~~For rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.~~

- 2) ~~The DRG grouper must be able to assign the claim to a DRG. The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost to charge ratio, as described in subsection (c)(3) of this Section, exceed the greater of:~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), \$34,000 as adjusted for the hospital's labor market, or the hospital's DRG-PPS base rate as described in Section 149.100(c)(1) multiplied by two.~~
 - B) ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission.~~

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- 3) ~~The estimated claim cost for a claim exceeds the claim outlier threshold for the DRG to which the claim has been assigned. The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under subsection (b) of this Section for discharges specified in Section 149.25(b)(4)(B), if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3), exceed:~~
- ~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the greater of the criteria specified in subsection (a)(2)(A) of this Section.~~
 - ~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the criteria specified in subsection (a)(2)(B) of this Section.~~
- 4) ~~The Department will not provide outlier payments for:~~
- ~~A) Discharges classified as psychiatric care (DRGs 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.~~
 - ~~B) Discharges assigned to DRGs with an Illinois weighting factor of zero (0.0000).~~
- 5) ~~The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as nonecovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:~~

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- A) ~~The admission was medically necessary and appropriate.~~
 - B) ~~The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.~~
 - C) ~~The services were ordered by the physician, actually furnished, and nonduplicatively billed.~~
 - D) ~~The validity of the diagnostic and procedural coding.~~
 - E) ~~The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a nonacute patient.~~
- b) Estimated claim cost. Estimated claim cost is based on the product of the claim total covered charges and the hospital's Medicare IPPS outlier cost-to-charge ratio. The Medicare IPPS outlier cost-to-charge ratio is determined based on: Payment for Extended Length of Stay Cases (Day Outliers)
- 1) For Medicare IPPS hospitals, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system hospital-specific operating and capital outlier cost-to-charge ratios effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred. If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.
 - 2) For non-Medicare IPPS hospitals and non-cost reporting hospitals located in an urban Medicare CSBA, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system statewide average operating and capital outlier cost-to-charge ratios for urban hospitals for the state in which the hospital is located, effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred. Except as provided in subsection (d) of this Section, and subject to the limitations described in subsection (e) of this Section, the per diem payment made under

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~~subsection (b)(1) is derived by first taking the marginal cost factor, as defined in 89 Ill. Adm. Code 149.5(c)(4), of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section 149.100(c)(3), by the mean length of stay for that DRG.~~

- ~~3) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.~~
- c) Exclusions. No outlier adjustment shall be paid on claims that are: Payments for Extraordinarily High Costs Cases (Cost Outliers)
 - 1) Inpatient psychiatric, rehabilitation and long-term acute care services excluded from the DRG PPS pursuant to Section 149.50(b). ~~If the hospital charges, as adjusted by the method specified in subsection (c)(3), exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.~~
 - 2) Claims for which Medicare is the primary payer. ~~The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost to charge ratio as described in subsection (c)(3), subject to the limitations described in subsections (c)(4) and (e) of this Section.~~
 - 3) ~~The cost to charge ratio used to adjust covered charges is computed at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), by the Department for each hospital based on the hospital's base fiscal year. Statewide cost to charge ratios are used in those instances in which a hospital's cost to charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).~~
 - 4) ~~If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.~~

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~~5) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers.~~

d) Outlier adjustment payment. The amount of the additional payment shall be determined as the product, rounded to the nearest hundredth, of:

- 1) the difference resulting from subtracting the claim outlier threshold from the estimated claim cost, and
- 2) the applicable Severity of Illness (SOI) adjustment factor, rounded to the nearest hundredth.

~~Payment for Extraordinary High Cost Day Outliers. If a discharge qualifies for an additional payment under the provisions of both subsections (b) and (c), the additional payment is, subject to the limitations described in subsection (e) of this Section, the greater of the following:~~

- ~~1) The payment computed under subsection (b) above.~~
- ~~2) The payment computed under subsection (c) above.~~

e) Definitions.

In addition to terms elsewhere defined in this subchapter, terms relating to outlier adjustments are defined as follows:

“Claim outlier threshold” means the sum of (i) the DRG base payment, as defined in Section 149.100(d) and the fixed loss threshold.

“Fixed loss threshold” means the Medicare fixed loss threshold in effect on the first day of October preceding the calendar year during which the inpatient discharge occurred; except for calendar year 2014, it means the Medicare fixed loss threshold in effect on October 1, 2012.

“MDC” means major diagnostic category.

“Medicare CBSA” means the Core-Based Statistical Areas for a hospital’s location effective in the Medicare inpatient prospective payment system at the

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beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

“Severity of Illness (SOI) adjustment factor” means for SOI 1, 0.8000; for SOI 2, 0.8000; for SOI 3, 0.9500; for SOI 4, 0.9500.

“Total covered charges” means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMS 1450), or one of its electronic transaction equivalents.

~~Outlier Payment Limitation. Notwithstanding any other provisions of this Section, the total reimbursement paid by the Department, excluding payments described in 89 Ill. Adm. Code 148.120, for a claim qualifying for an outlier payment under this Section shall not exceed the total covered inpatient charges.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.125 Special Treatment of Certain Facilities (Repealed)

a) **General Rules**

- 1) ~~Sole Community Hospitals. Hospitals defined as sole community hospitals shall, under subsection (b) below, shall have the choice of being reimbursed under the DRG-PPS methodology, as described in Sections 149.5 through 149.150, or the Department's Alternate Reimbursement methodology as described in 89 Ill. Adm. Code 148.250 through 148.300, in accordance with the provisions of 89 Ill. Adm. Code 148.40(f) through (h).~~
- 2) ~~Hospitals that Serve a Disproportionate Share of Low Income Patients. The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in 89 Ill. Adm. Code 148.120.~~
- 3) ~~Specific Inpatient Payment Adjustments. The Department shall make specific additional payments to applicable hospitals as set forth in 89 Ill. Adm. Code 148.290.~~

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- b) ~~Criteria for Classification as a Sole Community Hospital. "Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:~~
- 1) ~~Medicare Program Designation~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992.~~
 - B) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(B), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare program effective 90 days prior to the date of admission.~~
 - 2) ~~Primary Service Area Designation~~
 - A) ~~Any rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), that serves 55 percent or more of the Medicaid patients residing within the hospital's primary service area for the provision of inpatient hospital services.~~
 - B) ~~"Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.~~
 - 3) ~~The determination of sole community provider status under this subsection (b) shall be made prior to the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2).~~
 - 4) ~~The data used to make this determination will be from the Illinois Health Care Cost Containment Council (IHCCC) for the most recent four quarters for which information is available.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

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**Section 149.150 Payments to Hospitals Under the DRG Prospective Payment System
(Repealed)**

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- a) ~~Total Medicaid Payment. Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in subsections (b) through (c). In addition to the payments listed in subsections (b) through (c) of this Section, hospitals shall also receive disproportionate share adjustments in accordance with 89 Ill. Adm. Code 148.120, if applicable, uncompensated care adjustments in accordance with 89 Ill. Adm. Code 148.150, if applicable, and various specific inpatient payment adjustments in accordance with 89 Ill. Adm. Code 148.290, if applicable.~~
- b) ~~Payments Determined on a Per Case Basis. A hospital will be paid on a per case basis (with the exception of kidney acquisition costs) the following amounts:~~
 - 1) ~~the appropriate DRG PPS rate for each discharge as determined in accordance with Section 149.100(e).~~
 - 2) ~~The appropriate outlier payment amounts determined under Section 149.105.~~
 - 3) ~~Capital related costs as determined under subsection (c)(1)(A) of this Section.~~
- e) ~~Payments for Capital Costs. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) these costs shall be paid on a per case basis. For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), these costs shall be paid on a per diem basis. Payments for these costs shall be calculated as follows:~~
 - 1) ~~Capital Related Costs~~
 - A) ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):~~
 - i) ~~The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate~~

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- ~~period using the national total hospital market basket price proxies (DRI).~~
- ~~ii) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.~~
 - ~~iii) The adjusted capital related cost per diem amount, as calculated in subsection (c)(1)(A)(ii) above, shall be rank ordered for all hospitals and capped at the 80th percentile.~~
 - ~~iv) Each hospital shall receive a per case add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG-PPS.~~
- ~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):~~
- ~~i) Capital related cost per diem shall be calculated in accordance with subsections (c)(1)(A)(i) through (c)(1)(A)(iii) of this Section.~~
 - ~~ii) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) of this Section, whichever is less.~~
- ~~2) A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification.~~
- ~~d) Method of Payment~~
- ~~1) General Rule. Unless the provisions of subsection (d)(2) of this Section apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an~~

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~~excluded distinct part psychiatric or a rehabilitation unit of a hospital are made in accordance with 89 Ill. Adm. Code 148.270(b).~~

~~2) Special Interim Payment for Unusually Long Lengths of Stay~~

~~A) First Interim Payment. A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.~~

~~B) Additional Interim Payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under subsection (d)(2)(A) of this Section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of subsection (d)(2).~~

~~3) Outlier Payments. Except as provided in subsection (d)(2) of this Section, payment for outlier cases (described in Section 149.105) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.~~

~~e) Reductions to Total Payments~~

~~1) Copayments. Copayments are assessed in accordance with 89 Ill. Adm. Code 148.190.~~

~~2) Third Party Payments. Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~

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- f) ~~Effect of Change of Ownership on Payments Under the DRG Prospective Payment System. When a hospital's ownership changes, the following rule applies: Payment for the cost of inpatient hospital services for each patient, including outlier payments, as provided under subsection (b) of this Section, will be made to the entity that is the legal owner on the date of discharge. Payments will not be prorated between the buyer and seller.~~
- 1) ~~The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.~~
 - 2) ~~Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the information is attributable to a period during which a different party legally owned the hospital.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

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- 1) Heading of the Part: Hospital Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 152
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
152.100	Amendment
152.150	Amendment
152.200	Repeal
152.300	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11].
- 5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does affect units of local government. It will have an impact on county government entities that own or operate nursing facilities enrolled in the Medical Assistance Program.
- 12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
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217/782-1233

HFS.Rules@illinois.gov.

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
 - B) Reporting, bookkeeping or other procedures required for compliance: Yes, providers will have to report on Potentially Preventable Readmissions.
 - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on Which this Rulemaking Was Summarized: January 2014

The full text of the Proposed Amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER e: GENERAL TIME-LIMITED CHANGES

PART 152

HOSPITAL REIMBURSEMENT CHANGES

Section

152.100	Hospital Rate Reductions
152.150	Hospital Payment Documentation and Coding Improvement Adjustment Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
152.200	Non-DRG Reimbursement Methodologies (Repealed)
152.250	Appeals (Repealed)
152.300	Adjustment for Potentially Preventable Readmissions

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AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Sections 12-13 and 14-8 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and Sections 12-13 and 14-8].

SOURCE: Emergency rules adopted at 18 Ill. Reg. 2150, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10141, effective June 17, 1994; emergency amendment at 19 Ill. Reg. 6706, effective May 12, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10236, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16272, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9272, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15712, effective November 27, 1996; emergency amendment at 21 Ill. Reg. 9544, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16153, effective November 26, 1997; emergency amendment at 25 Ill. Reg. 218, effective January 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6966, effective May 28, 2001; emergency amendment at 25 Ill. Reg. 16122, effective December 3, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 7309, effective April 29, 2002; emergency amendment at 29 Ill. Reg. 10299, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19997, effective November 23, 2005; emergency amendment at 30 Ill. Reg. 11847, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18703, effective November 27, 2006; emergency amendment at 32 Ill. Reg. 529, effective January 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8730, effective May 29, 2008; amended at 35 Ill. Reg. 10114, effective June 15, 2011; emergency amendment at 36 Ill. Reg. 10410, effective July 1, 2012 through June 30, 2013; emergency amendment at 37 Ill. Reg. 282, effective January 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10517, effective June 27, 2013; emergency amendment at 37 Ill. Reg. 13589, effective August 1, 2013,

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for a maximum of 150 days; emergency amendment at 37 Ill. Reg. 16003, effective September 27, 2013, for a maximum of 150 days; amended at 38 Ill. Reg. 382, effective December 23, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 152.100 Hospital Rate Reductions

Notwithstanding any provision to the contrary in 89 Ill. Adm. Code 148 and 149 and this Part 152, effective for dates of service on or after July 1, 2012, any rate of reimbursement for services to hospitals or other payments to hospitals shall be reduced by an additional 3.5% from the rates that were otherwise in effect on July 1, 2012, and with implementation of SMART hospital payment reform rates in effect on July 1, 2014, implemented by 38 Ill. Reg. _____, effective _____, except that those reductions shall not apply to:

- a) Rates or payments for hospital services delivered by a hospital defined as a Safety Net Hospital under Section 5-5e.1 of the Illinois Public Aid Code [305 ILCS 5].
- b) Rates or payments for hospital services delivered by ~~a hospital defined as a Critical Access Hospital as defined in 89 Ill. Adm. Code 148.25(g), that is an Illinois hospital designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, subpart F.~~
- c) Rates or payments for hospital services delivered by a hospital that is operated by a unit of local government or State university that provides some or all of the non-federal share of the services.
- d) Payments authorized under Section 5A-12.4 of the Illinois Public Aid Code.
- e) Transitional payment authorized in 89 Ill. Adm. Code 148.296.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

**Section 152.150 Hospital Payment Documentation and Coding Improvement Adjustment
Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)**

Effective for dates of service on or after July 1, 2014:

- a) Inpatient Hospital Payment Documentation and Coding Improvement (DCI) Adjustment Notwithstanding any provisions set forth in 89 Ill. Adm. Code 149, the changes described in subsections (b) and (c) of this Section will be effective January 18, 1994.

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- 1) The Department shall monitor changes in inpatient hospital statewide average case mix for services provided in the first two years following implementation of the APR-DRG payment methodology, and retrospectively adjust DRG base rates to offset the impact of paid case mix differential attributable to DCI.
- 2) Measuring case mix differential attributable to DCI:
 - A) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the Medicare-Severity DRG (MS-DRG) grouper and relative weights for:
 - i) Claims with dates of service in State fiscal year 2011.
 - ii) Claims with dates of service in State fiscal years 2015 and 2016, consistent with subsection (a)(3) of this Section.
 - B) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the APR-DRG weighting factors for the same periods specified in subsection (a)(1)(A) of this Section.
 - C) The case mix differential that is attributable to DCI is equal to the difference between the change in the aggregate APR-DRG case mix and the change in the aggregate MS-DRG case mix, for the claims described in subsection (a)(1)(A) of this Section.
 - D) Claims for services provided in State fiscal years 2015 and 2016 that were not paid by the Department using the APR-DRG payment methodology shall be excluded when measuring the case mix differential.
- 3) Timing:
 - A) Calculate case mix differential attributable to DCI for claims with Dates of Service (DOS) in SFY 2015 (first year of implementation) as of:
 - i) July 1, 2015, using all claims adjudicated as of that date with DOS in SFY 2015.

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this adjustment, DRG base payment rate means the product of the PPS base rate, as described in 89 Ill. Adm. Code 149.100(e)(3), and the indirect medical education factor, as described in 89 Ill. Adm. Code 149.150(e)(3).

1) The Department shall monitor changes in outpatient hospital case mix for services provided in the first two years following implementation of the Enhanced Ambulatory Procedure Grouping (EAPG) payment methodology, and retrospectively adjust EAPG conversion factors to offset the impact of the case mix differential attributable to DCI.

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2) Measuring case mix differential attributable to DCI:

A) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Ambulatory Procedures List (APL) relative values for the claims data periods listed below. Relative values will be determined for each APL using State fiscal year 2011 outpatient claims data by dividing the APL's average payment per service unit by the statewide APL payment for service unit.

i) Claims with dates of service in State fiscal year 2011.

ii) Claims with dates of service in State fiscal years 2015 and 2016, consistent with subsection (b)(3) of this Section.

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B) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 3.7 of the EAPG grouper and the EAPG weighting factors for the same periods.

C) The case mix differential that is attributable to DCI is equal to the difference between the change in the aggregate EAPG case mix and the change in the aggregate APL case mix, for the claims described in subsections (i) and (ii) of this Section.

D) Claims for services provided in State fiscal years 2015 and 2016 that were not paid by the Department using the EAPG payment methodology shall be excluded when measuring the case mix differential.

3) Timing:

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- A) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2015 (first year of implementation) as of:
 - i) July 1, 2015, using all claims adjudicated as of that date with DOS in SFY 2015.
 - ii) January 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.
 - iii) April 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.
- B) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2016 (second year of implementation) as of:
 - i) July 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2016.
 - ii) January 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.
 - iii) April 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.
- 4) Adjusting for case mix changes attributable to DCI:
 - A) For any measurement period described above, if the case mix differential attributable to DCI is greater than two percentage points, the Department will adjust the EAPG conversion factor by the measured case mix differential less two percentage points.
 - B) For any measurement period described above, if the case mix differential attributable to DCI is less than minus two percentage points, the Department will adjust the EAPG conversion factor by the measured case mix differential plus two percentage points.
 - C) The Department will retroactively adjust the payments for all claims adjudicated as of the measurement period for the changes in the EAPG conversion factors.

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D) The EAPG conversion factor, after adjustments pursuant to subsections (b)(4)(A) and (B) of this Section, shall be in effect until the next measurement period.

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- e) ~~All payments calculated under 89 Ill. Adm. Code 149.140 and 149.150(c)(1), (c)(2) and (c)(4), in effect on January 18, 1994, shall remain in effect hereafter.~~
- d) ~~For hospital inpatient services rendered on or after July 1, 1995, the Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated pursuant to the methodology described in this Section, that were in effect on June 30, 1995, less the portion of such rates attributed by the Department to the cost of medical education.~~
- e) ~~Notwithstanding the provisions set forth in 89 Ill. Adm. Code 149 (DRG PPS), the changes described in this subsection (e) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(c)(3). This payment limitation shall not apply to or affect disproportionate share payments as described at 89 Ill. Adm. Code 148.120, payments for outlier costs as described at 89 Ill. Adm. Code 149.105 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).~~
- f) ~~Notwithstanding the provisions of 89 Ill. Adm. Code 149, payment for outlier cases pursuant to 89 Ill. Adm. Code 149.105 shall be determined by using the following factors that were in effect on June 30, 1995:~~
 - 1) ~~The marginal cost factor (see 89 Ill. Adm. Code 149.5(c)(4));~~
 - 2) ~~The Metropolitan Statistical Area (MSA) wage index (see 89 Ill. Adm. Code 148.120(b));~~
 - 3) ~~The Indirect Medical Education (IME) factor (see 89 Ill. Adm. Code 148.260(a)(1)(B)(iv));~~
 - 4) ~~The cost to charge ratio (see 89 Ill. Adm. Code 149.105(c)(3)), and~~
 - 5) ~~Outlier Threshold~~

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- A) ~~For admissions on December 3, 2001 through June 30, 2005, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.22.~~
- B) ~~For admissions on or after July 1, 2005 through June 30, 2006, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.40.~~
- C) ~~For admissions on or after July 1, 2006 through December 31, 2007, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.47.~~
- D) ~~For admissions on or after January 1, 2008, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.64.~~
- E) ~~For admissions on or after January 1, 2011, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.99.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 152.200 Non-DRG Reimbursement Methodologies (Repealed)

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- a) ~~Notwithstanding any provisions set forth in 89 Ill. Adm. Code 148, the changes described in subsection (b) of this Section will be effective January 18, 1994.~~
- b) ~~All per diem payments calculated under 89 Ill. Adm. Code 148, except for those described in 89 Ill. Adm. Code 148.120, 148.160, 148.170, 148.175 and 148.290(a), (c) and (d), in effect on January 18, 1994, less the portion of such rates attributed by the Department to the cost of medical education, shall remain in effect hereafter.~~
- e) ~~Notwithstanding the provisions set forth in 89 Ill. Adm. Code 148, Hospital Services, and 89 Ill. Adm. Code 146, Subpart A, Ambulatory Surgical Treatment Centers, the changes described in this subsection (c) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services and ambulatory surgical treatment services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(c)(3). This payment limitation shall not apply to or affect disproportionate share payments as described at 89 Ill. Adm. Code 148.120, payments for outlier costs as described at~~

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~~89 Ill. Adm. Code 148.130 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).~~

- d) ~~Notwithstanding the provisions of subsections (a), (b) and (c) of this Section, payment for outlier adjustments provided for exceptionally costly stays pursuant to 89 Ill. Adm. Code 148.130 shall be determined using the following factors:~~
 - 1) ~~For admissions on December 3, 2001 through June 30, 2005, a factor of 0.22 in place of the factor 0.25 described at 89 Ill. Adm. Code 148.130(b)(3)(D).~~
 - 2) ~~For admissions on or after July 1, 2005 through June 30, 2006, a factor of 0.20 in place of the factor 0.22 as described in subsection (d)(1) of this Section.~~
 - 3) ~~For admissions on or after July 1, 2006 through December 31, 2007, a factor of 0.18 in place of the factor 0.20 as described in subsection (d)(2) of this Section.~~
 - 4) ~~For admissions on or after January 1, 2008, a factor of 0.17 in place of the factor 0.18 as described in subsection (d)(3) of this Section.~~
- e) ~~Notwithstanding any other provisions of 89 Ill. Adm. Code 148 or 149 or this Part, long term acute care supplemental per diem rates, as authorized under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], effective July 1, 2012, shall be the amount in effect as of October 1, 2010. The July 1, 2012 rate will then be subject to the rate reductions detailed in Section 152.100. No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.~~
- f) ~~Notwithstanding any other provisions of 89 Ill. Adm. Code 148 or 149 or this Part, a hospital that is located in a county of the State in which the Department mandates some or all of its beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as defined in Section 5-30 of the Public Aid Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of the Public Aid Code that it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital as defined in 89 Ill. Adm. Code 148.295(g)(5), no later than August 14, 2012 or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care Program.~~

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(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 152.300 Adjustment for Potentially Preventable Readmissions

- a) Notwithstanding any provision set forth in 89 Ill. Adm. Code 148 or 149, the changes described in this Section will be effective January 1, 2013.
- b) For clean claims received on or after January 1, 2013, rates of payment to hospitals that have an excess number of readmissions, as defined in accordance with the criteria set forth in subsection (d), as determined by a risk adjusted comparison of the actual and targeted number of readmissions in a hospital as described by subsection (e), shall be reduced in accordance with subsection (f).
- c) Definitions. For purposes of this Section, the following terms are defined in this subsection (c). The definitions manual applicable to the PPR software created and maintained by the 3M Corporation that HFS will use to process admissions data and determine whether an admission is a Potentially Preventable Readmission can be accessed at www.aprdrgassign.com.
 - 1) "Potentially Preventable Readmission" or "PPR" shall mean a readmission meeting the readmission criteria in subsection (d) that follows a prior discharge from a hospital within 30 days and that is clinically-related to the prior hospital admission.
 - 2) "Hospital" shall mean a hospital as defined in 89 Ill. Adm. Code 148.25(b).
 - 3) "Clean Claim" shall mean a claim as defined in 42 CFR 447.45(b).
 - 4) "Clinically Related" shall mean that the underlying reason for readmission is plausibly related to the care rendered during a prior hospital admission. A clinically-related readmission results from the process of care and treatment provided during the prior admission (e.g., readmission for a surgical wound infection) or from a lack of post-admission follow up (e.g., lack of follow-up care arrangements with a primary physician) rather than from unrelated events that occurred after the prior admission (such as a broken leg due to trauma) within a specified readmission time interval.
 - 5) "Initial Admission" shall mean an admission to a hospital that is followed by a subsequent readmission or readmissions within 30 days that are

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determined by the 3M Corporation's PPR methodology to be clinically related.

- 6) "Only Admission" shall mean an admission without an associated readmission.
 - 7) "Potentially Preventable Readmission Chain" or "PPR Chain" shall mean an initial admission occurring at a hospital that is followed by one or more clinically-related PPRs. The PPRs may occur at the same hospital or a different hospital.
 - 8) "Qualifying Admission" shall mean the number of PPR chains plus the number of "Only Admissions", but specifically excludes the admissions detailed in subsection (d)(2).
 - 9) "Actual Rate" shall mean the number of PPR chains for a hospital divided by the total number of qualifying admissions for the hospital.
 - 10) "Targeted Rate of Readmissions" shall mean a risk adjusted readmission rate for each hospital that accounts for the severity of illness, APR-DRG, presence of behavioral health issues, and age of patient at the time of discharge preceding the readmission.
 - 11) "Excess Rate of Readmission" shall mean the difference between the actual rate of readmission and the targeted rate of readmission for each hospital.
 - 12) "Behavioral Health", for the purposes of risk adjustments, shall mean an admission that includes a secondary diagnosis of a major behavioral health related condition, including, but not limited to, mental disorders, chemical dependency and substance abuse.
- d) Readmission Criteria
- 1) A readmission is defined as an inpatient readmission within 30 days after discharge that is clinically related to the initial admission, as defined by the PPR software created and maintained by the 3M Corporation, and meets all of the following criteria:
 - A) The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on the

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3M software, in the prior discharge or during the post-discharge follow-up period.

- B) The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge.
 - C) The readmission is to the same or to any other hospital.
- 2) Admissions data, for the purposes of determining PPRs, excludes the following circumstances:
- A) The discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of the discharge and readmission are documented in the patient's medical record.
 - B) The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions, HIV, alcohol or drug detoxification, non-acute events (rehabilitation admissions), or, for hospitals defined in 89 Ill. Adm. Code ~~148.25(d)(4)~~~~149.50(e)(4)~~, admissions with an APR-DRG code other than 740 through 760.
 - C) The admission was for an individual who was dually eligible for Medicare and Medicaid, or was enrolled in a Medicaid Managed Care Entity (MCE)~~Managed Care Organization (MCO)~~.
- 3) Non-events are admissions to a non-acute care facility, such as a nursing home, or an admission to an acute care hospital for non-acute care. Non-events are ignored and are not considered to be readmissions.
- 4) Planned readmissions, as defined by 3M's team of clinicians, are accounted for in the 3M PPR software as an "Only Admission" and are not considered to be readmissions.
- e) Methodology to Determine Excess Readmissions
- 1) Rate adjustments for State fiscal year 2013 for each hospital shall be based on each hospital's 2010 medical assistance paid claims data for admissions that occurred between July 1, 2009 and June 30, 2010.

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- 2) Except as otherwise provided in subsection (f)(8), the targeted rate of readmission for each hospital shall be reduced by the percent necessary to achieve a savings of at least \$40 million in State fiscal year 2013 for hospitals other than the "large public hospitals" defined in 89 Ill. Adm. Code ~~148.25(a)+48.458(a)~~.
 - 3) Excess readmissions for each hospital shall be calculated by multiplying a hospital's qualifying admissions by the difference between the actual rate of PPRs and the targeted rate of PPRs, as adjusted in subsection (e)(2).
 - 4) In the event the actual rate of PPRs for a hospital is lower than the targeted rate of PPRs, the excess number of readmissions shall be set at zero.
- f) Payment Reduction Calculation
- 1) An average readmission payment per PPR chain for each hospital shall be calculated by dividing the total medical assistance net liability attributable to the readmissions associated with the hospital's PPR chains (excluding the liability associated with the initial admission) by the number of PPR chains for the hospital.
 - 2) The total excess readmission payments shall equal the average readmission payment per PPR chain, as determined in subsection (f)(1) multiplied by the excess readmissions as determined in subsection (e)(3).
 - 3) The total annual payment reduction for each hospital shall be the lesser of:
 - A) The total excess readmission payments as determined in subsection (f)(2); or
 - B) The total medical assistance payments for all hospital admissions, including admissions that were excluded from the PPR analysis, multiplied by 7%.
 - 4) A fiscal year 2013 hospital specific payment reduction factor for each hospital shall be computed as one minus the arithmetic operation of 25% of the total annual payment reduction, as determined in subsection (f)(3), divided by 50% of the total estimated medical assistance payments for all hospital clean claims received in fiscal year 2013.

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- 5) The hospital specific payment reduction factor, as determined in subsection (f)(4), shall be applied to the final payment amount for each clean claim received in fiscal year 2013.
 - 6) In order to achieve a savings of 25% of the annual payment reduction for each hospital, the hospital specific payment reduction factor may be adjusted to account for variances between the estimated payments to the hospital and the actual payments to the hospital.
 - 7) For those hospitals that have a payment reduction amount in State fiscal year 2013, a reconciliation of fiscal year 2013 claims will be calculated after January 1, 2014, after all inpatient hospital claims have been received by the Department, to determine how much of the remaining annual payment reduction must be recovered from the hospital. This reconciliation will determine how much of the annual payment reduction was offset in fiscal year 2013 by comparing the fiscal year 2013 rate of readmission to the base year (fiscal year 2010), as determined by subsection (e)(2). In addition, the reconciliation will account for changes in the average readmission payment per PPR chain from fiscal year 2010 to fiscal year 2013.
 - 8) After the Department verifies that all hospitals have achieved \$40 million savings in aggregate for FY2013 when compared to the base year, no further payment reductions will be applied to individual hospitals.
- g) Prior to June 30, 2013, administrative rules will be filed to determine the PPR adjustment methodology for fiscal year 2014 and thereafter.

(Source: Amended at 38 Ill. Reg. _____, effective _____)