DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hospital Services

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

3)

Section Numbers:	Proposed Action:
148.117	Amendment
148.122	Amendment
148.126	Amendment
148.295	Amendment
148.402	Repeal
148.404	Repeal
148.406	Repeal
148.408	Repeal
148.410	Repeal
148.412	Repeal
148.414	Repeal
148.416	Repeal
148.418	Repeal
148.420	Repeal
148.422	Repeal
148.424	Repeal
148.426	Repeal
148.428	Repeal
148.430	Repeal
148.432	Repeal
148.434	Repeal
148.440	New Section
148.442	New Section
148.444	New Section
148.446	New Section
148.448	New Section
148.450	New Section
148.452	New Section
148.454	New Section
148.456	New Section
148.458	New Section

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]

5) Complete Description of the Subjects and Issues Involved: The Department proposes

implementation of a revised Hospital Assessment program, beginning July 1, 2008. A principal purpose of the program is to provide funding for Medicaid reimbursable hospital services provided on and after that date. The proposed amendments to Part 148 revises certain provisions of several sections and repeals several sections associated with the current hospital assessment program. New reimbursement methodologies, along with definitions and provisions applicable to all of the new sections are also proposed. These changes are dependent upon enactment, by the General Assembly, of a revised assessment program and are subject to federal approval. The estimated annual impact is expected to be a little over $1.541 billion. These expenditures, if approved by the federal government, will be eligible for federal Medicaid matching funds. In addition, this material may be viewed at the DHS local offices (except in Cook County). In Cook County, the changes may be reviewed at the Office of the Director, Healthcare and Family Services, 100 West Randolph Street, Chicago, Illinois. The changes may be reviewed at all offices Monday through Friday from 8:30 a.m. until 5:00 p.m. This notice is being provided in accordance with federal requirements found at 42 *CFR* 447.205.

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

Sections	Proposed Action	Illinois Register Citation
148.130	Amendment	32 Ill. Reg. 303; January 11, 2008
148.126	Amendment	32 Ill. Reg. 2885; February 29, 2008
148.500	Amendment	32 Ill. Reg. 3552; March 14, 2008
148.510	Amendment	32 Ill. Reg. 3552; March 14, 2008

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 Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

addressed to:

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Chief of Staff
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor
Springfield IL 62763-0002

217/557-7157

The Department requests the submission of written comments within 30 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].

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid funded hospitals

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: the Department did not anticipate This rulemaking when the most recent regulatory agendas were published.

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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, 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 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 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. ____, effective _____.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.117 Outpatient Assistance Adjustment Payments

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.

4) 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 (IDPH) 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.

5) A hospital that has a MIUR of greater than 50 %, an emergency care percentage greater than 80%, and provided more than 6,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

6) A hospital that has a MIUR of greater than 70 % and an emergency care percentage greater than 90%.

7) A general acute care hospital, not located in Cook County, that is not a trauma center recognized by IDPH as of July 1, 2006, did not qualify for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has a MIUR of greater than 25%, an emergency care percentage greater than 50%, and provided more than 8,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

8) A general acute care hospital, not located in Cook County, that is a level I trauma center, recognized by IDPH as of July 1, 2006, 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.

9) 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, 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.

10) 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.

11) A rural hospital that has a MIUR of greater than 40% and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

12) A general acute care hospital, not located in Cook County, that is a trauma center, recognized by IDPH 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.

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 $336.25.

3) For hospitals qualifying under subsection (a)(3), the rate is $200.25.

4) For hospitals qualifying under subsection (a)(4), the rate is $217.25.

5) For hospitals qualifying under subsection (a)(5), the rate is $250.00.

6) For hospitals qualifying under subsection (a)(6), the rate is $336.25.

7) For hospitals qualifying under subsection (a)(7), the rate is $110.00

8) For hospitals qualifying under subsection (a)(8), the rate is $200.00.

9) For hospitals qualifying under subsection (a)(9), the rate is $48.50.

10) For hospitals qualifying under subsection (a)(10), the rate is $135.00.

11) For hospitals qualifying under subsection (a)(11), the rate is $65.00.

12) For hospitals qualifying under subsection (a)(12), the rate is $90.00.

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 2009 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.

d) Definitions

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 89 Ill. Adm. Code 149.50(c).

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 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.

(Source: Amended at 32 Ill. Reg. _____, effective_____)

Section 148.122 Medicaid Percentage Adjustments

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 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 may qualify for a Medicaid Percentage Adjustment in one of the following ways:

1) The hospitals Medicaid inpatient utilization rate (MIUR), as defined in Section 148.120(k)(4), is at least one-half standard deviation above the

mean Medicaid utilization rate, as defined in Section 148.120(k)(3).

2) The hospitals low income utilization rate 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(k)(4), that was at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(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)).

4) Illinois hospitals that:

A) Have an MIUR, as defined in Section 148.120(k)(4), that is at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3); and

B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (h)(3) of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (h)(2) of this Section.

5) Any children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(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 may apply to become a qualified Medicaid Percentage Adjustment

hospital under subsection (a)(2) of this Section by submitting audited certified financial 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 Sections 148.25(b)(1)(A) and 148.25(b)(1)(B).

1) The payment adjustment shall be calculated based upon the hospitals MIUR, as defined in Section 148.120(k)(4), and subject to subsections (e) and (f) 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 hospitals 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 hospitals 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 hospitals MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

2) (Reserved).

3) (Reserved).

4) The amount calculated pursuant to subsections (d)(1) through (d)(3) 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(k)(2), through DSH determination year 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 (h)(5) of this Section, over the previous years Statewide average hospital payment rate.

5) The amount calculated pursuant to subsections (d)(1) through (d)(4) of this Section, as adjusted pursuant to subsections (e) and (f) 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)(4) 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 89 Ill. Adm. Code 149.50(c)(3), the payment adjustment calculated under subsection (d)(1) of this Section shall be multiplied by 2.0.

f) DSH for Government-Owned or Operated Hospitals.

1) The following classes of government-owned or operated Illinois hospitals shall, subject to the limitations set forth in subsection (g) of this Section, be eligible for the disproportionate share hospital adjustment payment

A) Hospitals defined in Section 148.25(b)(1)(A).

B) Hospitals owned or operated by a unit of local government that is not a hospital defined in subsection (A) of this Section.

C) Hospitals defined in Section 148.25(b)(1)(B).

2) The annual amount of the payment shall be the amount computed for the hospital pursuant to federal limitations, adjusted from the midpoint of the cost report period to the midpoint of the rate period using the CMS Hospital Price Index.

3) The annual amount shall be paid to the hospital in monthly installments. The portion of the annual amount not paid pending approval of payments pursuant to federal approval shall, upon approval, be paid in a single lump sum payment. The annual amount shall be paid to the hospital in twelve equal installments and paid monthly.

g) 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 at the hospital to perform nonemergency obstetric procedures. 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 89 Ill. Adm. Code 149.50(c)(1) through (c)(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 nonemergency obstetrical care. The provisions of this subsection (g)(2) shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency 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 nonemergency obstetrical care.

3) Appeals based upon a hospitals 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 hospitals eligibility for Medicaid Percentage payment adjustments or a change in a hospitals 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(k)(4), is less than one percent.

h) 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 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 (h)(4) of this Section, provided by all Medicaid-participating Illinois hospitals 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 inpatient days, as defined in subsection (h)(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 DSH determination year and contained within the Departments 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 (h)(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 (h)(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 Departments 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 Departments paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, with a Diagnosis Related Grouping (DRG) of 370 through 375, and specifically excludes Medicare/Medicaid crossover claims.

5) Statewide average hospital payment rate means the hospitals alternative reimbursement rate, as defined in Section 148.270(a).

6) Total Medicaid (Title XIX) inpatient days, as referred to in subsections (h)(2) and (h)(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 Departments paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

7) Medicaid obstetrical inpatient utilization rate base year means, 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.

(Source: Amended at 32 Ill. Reg. _____, effective_____)

Section 148.126 Safety Net Adjustment Payments

EMERGENCY

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).

4) The hospital is, as of October 1, 2001, a rural hospital, as described in Section 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).

6) 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.

7) The hospital meets all of the following criteria:

A) Does not already qualify under subsections (a)(1) through (a)(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.

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.

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

A) Is a psychiatric hospital, as described in 89 Ill. Adm. Code 149.50(c)(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.

11) 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)(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.

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)(13) of this Section.

B) Has a CMIUR 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) (Reserved).

16) 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(c), and functions as an overflow emergency room for its affiliate hospital provider.

17) The hospital has an MIUR greater than 90% in the safety net hospital base year.

18) 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)(17) of this Section.

B) Located outside HSA 6.

C) Has a MIUR greater than 16%.

D) Has licensed beds greater than 475.

E) Has an average length of stay less than five days.

19) The hospitals meet 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%.

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)(16) and subsections (a)(18) 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(c)(1).

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

c) 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.

B) A rehabilitation hospital, as described in 89 Ill. Adm. Code 149.50(c)(2) – $20.00.

C) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(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.

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.

J) 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:

i) Provides obstetrical care – $280.00.

ii) Does not provide obstetrical care – $120.00.

iii) Is a trauma center, recognized by the Illinois Department of Public Health (IDPH), 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 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.

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.

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:

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.

7) For a hospital qualifying under subsection (a)(7) of this Section, 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 $85.50.

10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is $13.75.

11) For a hospital qualifying under subsection (a)(11) of this Section, the rate is $39.50.

12) For a hospital qualifying under subsection (a)(12) of this Section, the rate is $240.50.

13) For a hospital qualifying under subsection (a)(13) of this Section, the rate is $231.50.

14) For a hospital qualifying under subsection (a)(14) of this Section, the rate is $443.75.

15) (Reserved).

16) For a hospital qualifying under subsection (a)(17) of this Section, the rate is $39.50.

17) For a hospital qualifying under subsection (a)(18) of this Section, the rate is $69.00.

18) For a hospital qualifying under subsection (a)(19) of this Section, the rate is $16.00.

d) 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 safety net adjustment periods occurring after State fiscal year 2009, total payments will equal sum of amounts calculated under the methodologies described in subsection (c) of this Section and shall be paid

to the hospital during the safety net adjustment period in installments on, at least, a quarterly basis.

e) 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.

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 148.120(k)(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" means, for a given hospital, has the meaning as defined in Section 148.120(k)(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.

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.

(Source: Amended at 32 Ill. Reg. _____, effective_____)

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

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

a) Trauma Center Adjustments (TCA)
The Department shall make a TCA to Illinois hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (IDPH) in accordance with the provisions of subsections (a)(1) through (a)(4) of this Section. For the purpose of a TCA, a children's hospital, as defined under 89 Ill. Adm. Code 149.50(c)(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. Illinois hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by IDPH shall receive the Level I trauma center adjustment. Hospitals qualifying under subsection (a)(2) are not eligible for payment under this subsection.

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

i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of $21,365.00 per Medicaid trauma admission in the CHAP base period.

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

2) Level I Trauma Center Adjustment for Illinois hospitals located in the same city, that alternate their Level I trauma center designation.

A) Criteria. Illinois hospitals that are located in the same city and participate in an agreement in effect as of July 1, 2007, whereby their 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 $5,250.00 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 $3,625.00 per Medicaid trauma admission for that class in the CHAP base period.

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

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

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

B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(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).

b) Rehabilitation Hospital Adjustment (RHA)
Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), and that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:

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

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

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

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

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

c) Direct Hospital Adjustment (DHA) Criteria

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

ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999 and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

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

B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999 and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

C) Children's hospitals, as defined under 89 Ill. Adm. Code 149.50(c)(3), on July 1, 1999.

D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.

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

F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999 and provided more than 7,500 Total days and provided obstetrical

care as of July 1, 2001.

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

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

I) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(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 (c)(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(c), 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 (c)(1)(A) of this Section, the DHA rates are as follows:

i) Hospitals that have a Combined MIUR that is equal to or

greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive $69.00 per day for hospitals that do not provide obstetrical care and $105.00 per day for hospitals that do provide obstetrical care.

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

iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $124.00 per day for hospitals that do not provide obstetrical care and $160.00 per day for hospitals that do provide obstetrical care.

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

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

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

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

iii) Hospitals with more than 80,000 Total days will have their

rate increased by an additional $423.00 per day.

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

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

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

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

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

ix) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than four days will have their rate increased by $528.00 per day.

x) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by $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 $98.00 per day.

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

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

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

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

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

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

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

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

v) Hospitals with more than 3,200 Total admissions will have their rate increased by $328.00 per day.

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

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

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

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

$110.25 per day.

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

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

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

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

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

ii) Hospitals with an MIUR greater than 19.75 percent, but equal to or less than 20.00 percent, will receive a rate of $69.00 per day.

iii) Hospitals with an MIUR greater than 20.00 percent will receive a rate of $110.00 per day.

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

J) Hospitals qualifying under subsection (c)(1)(I) of this Section will receive a rate of $328.00 per day.

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

3) DHA Payments

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

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

C) Total Payment Adjustments

i) For the CHAP rate period occurring in State fiscal year 2008, total payments will equal the methodologies described in subsection (c)(2) of this Section.

ii) For CHAP rate periods occurring after State fiscal year 2008, total payments will equal the methodologies described in subsection (c)(2) of this Section.

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

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

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

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

f) Critical Hospital Adjustment Limitations
Hospitals that qualify for trauma center adjustments under subsection (a) of this Section shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment

described in subsection (a)(1) of this Section, or a Level II trauma center as required for the adjustment described in subsection (a)(2) or (a)(3) of this Section. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased. This limitation does not apply to hospitals qualifying under subsection (a)(2).

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

1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.

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

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

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

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

6) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0

through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.

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

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

9) "Medicaid trauma admission" means those claims billed as admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31, 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 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.

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

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

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

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

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

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

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.402 Medicaid Eligibility Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.404 Medicaid High Volume Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.406 Intensive Care Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.408 Trauma Center Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.410 Psychiatric Rate Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.412 Rehabilitation Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.414 Supplemental Tertiary Care Adjustment Payments (Repealed)

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(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.416 Crossover Percentage Adjustment Payments (Repealed)

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(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.418 Long Term Acute Care Hospital Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective_____)

Section 148.420 Obstetrical Care Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.422 Outpatient Access Payments (Repealed)

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(Source: Amended at 32 Ill. Reg._____, effective _____)

Section 148.424 Outpatient Utilization Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.426 Outpatient Complexity of Care Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.428 Rehabilitation Hospital Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg.____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 148.430 Perinatal Outpatient Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.432 Supplemental Psychiatric Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.434 Outpatient Community Access Adjustment Payments (Repealed)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 148.440 High Volume Adjustment Payments (New Section)

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.

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.442 Inpatient Services Adjustment Payments (New Section)

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.

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 described in Section 148.298, multiplied by:

A) 2.50, for a hospital that is a freestanding children's hospital

B) 1.00, for any other hospital.

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.444 Capital Needs Payments (New Section)

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

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.446 Obstetrical Care Payments (New Section)

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 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.

NOTICE OF PROPOSED AMENDMENTS

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.448 Trauma Care Payments (New Section)

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:

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. Admin. Code 148.295(a)(3) and (a)(4).

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 identified in 89 Ill. Admin. Code 148.295(a).

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

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.450 Supplemental Tertiary Care Payments (New Section)

a) Qualifying criteria. An Illinois hospital that qualified in State fiscal year 2007 for a payment described in Section 148.296.

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.

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.452 Crossover Care Payments (New Section)

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 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 days provided to individuals eligible Medicaid, as recorded in the Department's paid claims data.

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.454 Magnet Hospital Payments (New Section)

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 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 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.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.

(Source: Added at 32 Ill. Reg._____, effective_____)

NOTICE OF PROPOSED AMENDMENTS

Section 148.456 Ambulatory Procedure Listing Increase Payment (New Section)

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 described in subsection 148.140(b)(1)(e) 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 described in Sections 148.140(b)(1)(A) through 148.140(b)(1)(D) and,

B) 2.20.

(Source: Added at 32 Ill. Reg._____, effective_____)

Section 148.458 General Provisions (New Section)

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.

"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 149.50(c)(4).

"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 148.40(a)(7).

"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(K)(4).

b) Payment. The annual amount of each payment for which a hospital qualifies shall be made in twelve equal installments on or before the seventh State business day of each month. If a hospital closes or ceases to do business, payments will be prorated based on the number of days hospital was open during the State fiscal year in which the hospital closed or ceased to do business. In the case of the

merger of two or more hospital providers that did conduct, operate or maintain separate hospitals during the hospital's fiscal year 2005, the payments to the merged hospital provider for the State fiscal year shall be computed based on the individual data of the hospitals that were subject of the merger for each hospital's fiscal year 2005.

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 post marked 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.

(Source: Added at 32 Ill. Reg._____, effective_____)