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State/Territory Name: IL

State Plan Amendment (SPA) #: 03-0017-A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

AUG 19 2014

Ms. Julie Hamos, Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

RE: Illinois State Plan Amendment (SPA) 03-017A

Dear Ms. Hamos:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 03-017A. Effective for inpatient hospital services on or after October 1, 2003, this amendment provides inpatient supplemental payments to providers that meet specified Medicaid inpatient utilization rate thresholds.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 03-017A is approved effective October 1, 2003. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Michelle Beasley at (312) 353-3746 or via email at Michelle.Beasley@cms.hhs.gov.

Sincerely,

[redacted]

Cindy Mann
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **03-17A**

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: **Title XIX of the Social Security Act (Medicaid)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2003**

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY '04 $ 0.0
b. FFY '05 $ 0.0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Pages 39-56, 50A 50B 50C
60-63, 56A 56B 56C
92-101 [redacted], 62A 63B 63C
[redacted] 63D 63E 63F

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, Pages 39-56,
60-63,
[redacted], 92-101
[redacted]

10. SUBJECT OF AMENDMENT:

The change reclassifies certain Disproportionate Share (DSH) hospital payments as inpatient payments.

11. GOVERNOR'S REVIEW *(Check One)*

[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **Barry S. Maram**

14. TITLE: **Director of Public Aid**

15. DATE SUBMITTED: 12/31/03

16. RETURN TO:
Illinois Department of Public Aid
Bureau of Program and Reimbursement Analysis
Attn: Frank Kopel, Chief
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: AUG 19 2014

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: Oct. 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy + Financial Mgt. CMCS

23. REMARKS:

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07/91 C. Special Treatment: Hospitals That Serve a Disproportionate Share of Low Income Patients

10/03 1. Qualified Disproportionate Share Hospitals (DSH)

Disproportionate Share (DSH) adjustments for inpatient services provided prior to October 1, ~~1993~~2003, shall be determined and paid in accordance with State plans governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, ~~1993~~2003, and each October 1, thereafter, unless otherwise noted. For inpatient services provided on or after October 1, ~~1993~~2003, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

10/03 a. The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section C.8.de., is at least one ~~half~~ standard deviation above the mean Medicaid inpatient utilization rate, as defined in Section C.8.c.

03/95 b. The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children, Transitional and Interim Assistance (formerly known as General Assistance), Aid to the Medically Indigent (AMI) 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, Transitional, and Interim Assistance (formerly known as General Assistance), AMI inpatient hospital services, and/or any local or state government-funded care) must be added.

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~~10/93 c. Illinois hospitals that, on July 1, 1991, had a Medicaid inpatient utilization rate, as defined in Section C.8.e., that was at least the mean Medicaid inpatient utilization rate, as defined in Section C.8.e., and which 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 CRF, 5, 1989).~~

~~10/92 d. Illinois hospitals that:~~

~~10/92 i. Have a Medicaid inpatient utilization rate, as defined in Section C.8.e., which is at least the mean Medicaid inpatient utilization rate, as defined in Section C.8.e., and~~

~~10/92 ii. Also have a Medicaid obstetrical inpatient utilization rate, as defined in Section C.8.f., that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in Section C.8.d.~~

~~07/98 e. Any children's hospital, as defined in Chapter II.C.3. of this Attachment.~~

10/92 2. In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges 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 Sections C.1. through C.4. of Chapter II., must submit a statement to that effect.

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10/03 3. In making the determination described in Sections C.1.a. ~~and C.1.d.~~ of this Chapter, the Department shall utilize:

a. Hospital Cost Report

i. The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in Section C.8.de. of this Chapter, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Chapter IX., with the exception of errors in calculation.

10/03 ~~b.~~ ii. In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in Sections C.1.a. ~~and C.1.d.~~ of this Chapter. Submittal of a corrected cost report in support of Sections C.1.a. ~~and C.1.d.~~ of this Chapter must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's ~~Medicaid inpatient utilization rate~~MIUR as described in Section C.8.de. of this Chapter.

iii. In the event of extensions to the Medicare cost report filing process, those hospitals that do not have an audited or unaudited base year Medicaid cost report on file with the Department by the 30th of April preceding the DSH determination are required to complete and submit to the Department a Hospital Day Statistics Collection (HDSC) form. On the form, hospitals must provide total Medicaid days and total hospital days for the hospital's base fiscal year. The HDSC form must be submitted to the Department by the April 30th preceding the DSH determination.

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A) If the Medicare deadline for submitting base fiscal year cost reports falls within the month of June preceding the DSH determination, hospitals, regardless of their base fiscal year end date, will have until the first day of August preceding the DSH determination to submit changes to their Medicaid cost reports for inclusion in the final DSH calculations. In this case, the HDSC form will not be used as a data source for the final rate year DSH determination

B) If the Medicare deadline for submitting base fiscal year cost reports is extended beyond the month of June preceding the DSH determination, the HDSC form will be used in the final DSH determination for all hospitals that do not have an audited or unaudited Medicaid cost report on file with the Department. Hospitals will have until the first day of July to submit any adjustments to the information provided on the HDSC form sent to the Department on April 30th.

iv. Hospitals' Medicaid inpatient utilization rates, as defined in Section C.8.de. of this Chapter, which have been derived from unaudited cost reports or the HDSC form, are not subject to the Review Procedure described in Chapter IX., with the exception of errors in calculation. Pursuant to Sections ~~C.3.b.~~ C.3.a.ii.and C.3.a.iii.B) of this Chapter, hospitals shall have the opportunity to submit corrected ~~cost report~~ information prior to the Department's final DSH determination.

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v. In the event a subsequent final audited cost report reflects a ~~Medicaid inpatient utilization rate~~MIUR, as described in Section C.8.de. of this Chapter, which is lower than the ~~Medicaid inpatient utilization rate~~MIUR derived from the unaudited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.

~~c.~~b. Days Not Available from Cost Report
Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid ~~Health Maintenance~~ Managed Care Organization (MCO)(~~HMO~~) days, hospital residing long term care days, and ~~Department of~~ Medicaid days for Alcohol and Substance Abuse (ASA) rehabilitative care. ~~(DASA) Medicaid days~~. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

i. Medicare/Medicaid Crossover Claims.

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A) For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the remainder of Section C.3.c.i of Chapter VI will not be used in the determination process for DSH determination years on or after October 1, 1996.

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

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10/92 ii. Out-of-State Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

iii. ~~HMO~~ MCO Days. The Department will utilize the Department's ~~HMO~~ MCO claims data available to the Department as of the last day of June preceding the DSH determination year, or specific claim information from each MCO for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an ~~HMO~~ MCO.

10/93 iv. Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.

10/03 v. Alcohol and Substance Abuse~~ASA~~ Days. The Department will utilize the Department's ASA paid claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient ASA days provided.

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10/03 4. Hospitals may apply for DSH status under Section C.1.b. of this Chapter, by submitting an audited certified financial statement for the hospital's base fiscal year. ~~The Department of Mental Health and Developmental Disabilities must submit a statement, signed by the Director of that agency, certifying the accuracy of the data submitted for the facilities operated by that agency~~ to the Department of Human Services or the Department of Public Aid. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:

10/92 a. Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

10/92 b. Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

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10/93 c. Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance, and AMI patients), for the hospital's base fiscal year.

10/92 d. Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

10/03 5. With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the State in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under Sections C.7.a. and C.7.b. of this Chapter. For purposes of determining the ~~Medicaid inpatient utilization rate~~MIUR, as described in Section C.8.de. and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the ~~Medicaid inpatient utilization rate~~MIUR from their state may submit an audited certified financial statement as described in Section C.4. Payments to out-of-state hospitals will be allocated using the same methods as described in Section C.7.

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10/92 6. Time Limitation Requirements for Additional Information

a. Unless specifically stated otherwise in the applicable administrative rule, the ~~The~~ information required in Sections C.1.~~b~~., C.3., C.4., and C.5., must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in this Chapter which is not received in compliance with these limitations will not be considered or the determination of those hospitals qualified for DSH adjustments.

10/03 b. The information required in Section C.2. must be ~~received within 30 calendar days~~submitted after ~~of~~ receipt of notification from the Department ~~that the information must be submitted~~. Information required in this section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

10/92 7. Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by Section C.1. of this Chapter shall be calculated annually as follows:

03/95 a. Five Million Dollar Fund Adjustment for Hospitals Defined in Chapter XV, Sections A.1. and A.2.

10/03 i. Hospitals qualifying as DSH hospitals under Section C.1.a., ~~that have a Medicaid inpatient utilization rate, as described in Section C.8.c., which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in Section C.8.c., and hospitals qualifying as DSH hospitals under~~or Section C.1.b. of this Chapter will receive an add-on payment to their inpatient rate.

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ii. The distribution method for the add-on payment described in Section C.7.a.i. above is based upon a fund of $5 million. All hospitals qualifying under Section C.7.a.i. above will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

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~~10/93~~10/03

iii. The remaining fund balance is then distributed to the hospitals that qualify under Section C.1.a. of this Chapter ~~that have a Medicaid inpatient utilization rate, as described in Section C.8.e, which is at least one standard deviation above the mean Medicaid inpatient utilization rate,~~ as described in Section C.8.c., in proportion to the percentage by which the hospital's ~~Medicaid inpatient utilization rate~~MIUR exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the $5 per day base add-on has been subtracted.

10/03

iv. The total dollar amount calculated for each qualifying hospital under Section C.7.a.iii., (plus the initial $5 per day add-on amount calculated for each qualifying hospital under Section C.7.a.ii.,) is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at per day add-on value. Hospitals qualifying under Section C.1.b. of this Chapter will receive the minimum adjustment of $5 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in Section C.7.g. of this Chapter. The adjustments calculated under Section 7 shall be paid on a per diem basis and shall be applied to each covered day of care provided.

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~~07/95~~ ~~b. Medicaid Percentage Adjustment for Hospitals defined in Chapter XVI, Sections A.1. and A.2., excluding hospitals defined in Section A.1.a.i. of Chapter XVI.~~

~~i. In addition to the adjustment methodology described in Section C.7.a. of this Chapter all DSH hospitals described in Sections C.1.a., C.1.b., C.1.c., C.1.d., and C.1.e. of this Chapter shall receive a payment adjustment which shall be calculated annually as follows:~~

~~07/95~~ ~~ii. The payment adjustment shall be calculated based upon the hospital's Medicaid inpatient utilization rate, as defined in Section C.8.e. of this Chapter, and subject to Sections C.7.d. and C.7.e. of this Chapter, as follows:~~

~~10/93~~ ~~A) Hospitals with a Medicaid inpatient utilization rate below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;~~

~~10/93~~ ~~B) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;~~

~~10/93~~ ~~C) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and~~

~~10/93~~ ~~D) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's Medicaid~~

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~~inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.~~

~~07/95~~ ~~iii. For hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., the amount calculated pursuant to Section C.7.b.ii. above shall be increased by $60 per day.~~

~~07/95~~ ~~iv. The Medicaid percentage adjustment payment, calculated in accordance with this Section, to a hospital, other than hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., shall not exceed $155 per day for a children's hospital, as described in Section C.1.e. of this Chapter, and shall not exceed $215 per day for all other hospitals.~~

~~03/95~~ ~~v. The amount calculated pursuant to Section C.7.b.ii. through C.7.b.iv. above shall be adjusted on October 1, 1993, and annually thereafter, by a percentage equal to the lesser of:~~

~~10/92~~ ~~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~~

~~10/93~~ ~~B) The percentage increase in the statewide average hospital payment rate, as described in Section C.8.h. of this Chapter, over the previous year's statewide average hospital payment rate.~~

~~07/95~~ ~~vi. The amount calculated pursuant to Section C.7.a. above for a hospital described in Section A.1.a.i. of Chapter XVI. shall be no less than the DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~07/95~~ ~~vii. The amount calculated pursuant to Sections C.7.a. and C.7.b.ii. through C.7.b.v. of this Chapter as adjusted pursuant to~~

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~~Sections C.7.d. and C.7.e. shall be the inpatient payment adjustment in dollars for the applicable DSH determination year, subject to the limitations described in Sections C.7.b.iv. and C.7.f. of this Chapter, and the adjustment described in Section C.7.b.vi. above. The adjustments calculated under Sections C.7.a. and C.7.b.ii. through C.7.b.vi. of this Chapter shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

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10/00 c. Department of Human Services (DHS)State-Operated Facility Adjustment for Hospitals defined in Chapter XVI, Section A.7. Department of Human Services' State-operated facilities qualifying under Section C.1.b., shall receive an adjustment effective for inpatient services on or after March 1, 1995. Effective October 1, 2000, the adjustment payment shall be calculated as follows.

==10/~~00~~03 i. The amount of the adjustment is based on a State DSH Pool. The State DSH pool amount shall be the lesser of the federal DSH allotment for mental health facilities as determined in Ssection 1923(h) of the Social Security Act, minius the estimated DSH payments to such facilities that are not operated by the State; or the result of ~~calculated by~~ subtracting the estimated DSH payment adjustments made under Sections C.7.a ~~through C.7.b~~e and f. of this Chapter, and Chapter XIV, Section F.2. from the aggregate DSH payment allotment as provided for in section 1923(f) of the Social Security Act .

10/00 ii. The State DSH Pool amount is then allocated to hospitals defined in Chapter XVI, Section A.7. that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uninsured care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uninsured care costs.

10/03 iii. The adjustment calculated in Section C.7.~~e~~c.ii. of this Chapter shall meet the limitation described in Section C.7.f.iv. of this Chapter.

10/03 iv. The adjustment calculated pursuant to Section C.7.c.ii. above, for each hospital defined in Chapter XVI, Section A.7. that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in Section ~~C.7.f~~C.7.g. of this Chapter. The adjustment described in this Chapter shall be paid on a quarterly basis.

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10/03 d. Assistance for Certain Public Hospitals

i. The Department may make an annual payment adjustment to qualifying hospitals in the DSH determination year in accordance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Section 701(d).

ii. Hospitals qualifying shall receive an annual payment adjustment that is equal to the product of subsections A) and B) below:
~~2.~~A. A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Section 701(d)(3)(B), for the DSH determination year, divided first by Illinois' Federal Medical Assistance Percentage, and divided secondly by the sum of the qualified hospitals total Medicaid inpatient days as defined in subsection (8)(i) of this section; and,
~~3.~~B.Each qualified hospital's Medicaid inpatient days as defined in subsection (8)(i) of this section.

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~~iii. Payment adjustments under subsection (d) shall be made without regard to sections 1923(f) and 1923(g) of the Social Security Act, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.~~

iii~~v~~. ~~For DSH rate year 2002 the annual payment adjustment calculated under this subsection, for each qualified hospital, will be divided by two and paid on a quarterly basis. For DSH rate years after DSH rate year 2002 the~~The annual payment adjustment calculated under this subsection, for each qualified hospital, will be divided by four and paid on a quarterly basis.

iv. Payment adjustments under subsection (d) shall be made without regard to sections 1923(f) and 1923(g) of the Social Security Act, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

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~~07/95~~ ~~d.e. Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Section C.1.e. of this Chapter, the payment adjustment calculated under Section C.7.b. above shall be multiplied by 2.0.~~

10/03 e. Hospitals Organized Under the University of Illinois Hospital Act. For a hospital and /or hospitals organized under the University of Hospital Act, as defined in Section A.1.a.ii of Chapter XVI, the payment adjustments calculated under Section C 9shall be considered disproportionate adjustments.

10/03 f. ~~.Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital organized under the University of Illinois Hospital Act, as defined in Section A.1.a.ii. of Chapter XVI., the payment adjustment calculated under Section C.7.b. above shall be multiplied by 1.50.~~ For county owned hospitals defined in ChapterXIVA.1.a.i a portion of the payments made in accordance with Chapter XIIIF.3.a.ii and Chapter XV.D.10.c may be considered disproportionate share adjustments as described in Chapter XIIIF.3.a.ii and Chapter XV.D.10.c.

07/95 g. DSH Adjustment Limitations.

~~10/93~~10/03 i. Hospitals that qualify for DSH adjustments under this Chapter shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues the provision of non-emergency obstetrical care (the provisions of this subsection shall not apply to those hospitals described in Sections C.1. through C.4. of Chapter II., or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987). In this instance, the adjustments calculated under Sections C.7.a.~~ and C.7.b.~~ shall cease to be effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.

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ii. Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Chapter IX., which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital that has received notification from the Department of their eligibility for DSH payment adjustments based upon the requirements of this Chapter.

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iii. DSH Payment Adjustment. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Chapter do not meet the State's final DSH Allotment as determined by the Health Care Financing Administration (HCFA), DSH payment adjustments calculated under this section shall be adjusted to meet the State DSH Allotment. This adjustment shall first be applied to DSH payments made under Section C.7.c. above. ~~If further adjustments are necessary, then DSH payments made under Section C.7.b. above shall be adjusted, with the DSH payments made under Section C.7.a. being adjusted last.~~

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07/95 iv. Omnibus Budget Reconciliation Act of 1993 (OBRA '93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospital's disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. The adjustment to hospitals will be computed by determining a hospitals cost of inpatient and outpatient services furnished to Medicaid patients, less the amount paid to the hospital for inpatient and outpatient services excluding DSH payments made under this State plan. The cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these patients shall be determined and added to the Medicaid shortfall calculated above. The result shall be compared to the hospitals estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospitals DSH rate per day so that their DSH payments will equal the DSH limit. If necessary, retroactive adjustments will be made.

10/03 v. Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's ~~Medicaid inpatient utilizaiton rate~~MIUR, as defined in Section C.8.de. of this Chapter, is less than one percent.

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07/91 8. Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

10/~~93~~03 a. "Base fiscal year" means, for example, the hospital's fiscal year ending in ~~1991~~ 2003 for the October 1, ~~1993~~2003, DSH determination year, the hospital's fiscal year ending in ~~1992~~ 2002 for the October 1, ~~1994~~2004, DSH determination year, etc.

10/93 b. "DSH determination year" means, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

c. "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et. seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Sections C.3.a and C.3.b. of this Chapter. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

~~d. "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 Section C.8.g. below, 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 U.S.C. Sec. 1396a et. seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in Section C.8.i. below, for all such hospitals. This information shall be derived from claims for applicable services provided in the~~

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~~Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims database.~~

10/93 de. "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et. seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Sections C.3.a and C.3.b of this Chapter. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

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~~07/95~~ ~~f. "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in Section C.8.g. below, 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 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in Section C.8.i. below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.~~

~~07/95~~ ~~g. "Medicaid (Title XIX) obstetrical inpatient days" means, hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, with a Diagnosis Related Group (DRG) of 370 through 375), and specifically excludes Medicare/Medicaid crossover claims.~~

~~10/93~~ ~~h. "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section B.1. of Chapter VIII.~~

~~10/93~~ ~~i. "Total Medicaid (Title XIX) inpatient days", as referred to in Sections C.8.d. and C.8.f. above, means, hospital inpatient days, excluding days for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.~~

~~10/93~~ ~~j. "Medicaid obstetrical inpatient utilization rate base year" means, for example, state fiscal year 1992 for the October 1,~~

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~~1993, DSH determination year; state fiscal year 1993 for the October 1, 1994, DSH determination year, etc.~~

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07/95 c. "TCA base period" means State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period, State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.

07/95 d. "TCA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

07/95 e. "Trauma Center Fund " means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds received by the Department as a result of expenditures made by the Department as required by Section E.4.

07/95 F. Medicaid High Volume Adjustments (MHVA)

~~07/95~~10/03 For inpatient admissions occurring on or after October 1, ~~1993~~2003, the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals.

07/95 1. Criteria. To qualify for MHVA adjustments under this Section, hospitals must meet the following criteria:

10/03 a. Be eligible to receive the adjustment payments described in Section G~~C~~. of this Chapter in the MHVA rate period; and

07/95 b. Not be a county-owned hospital, as described in Section A.1.a.i. of Chapter XVI., or a hospital organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., in the MHVA rate period; and

~~07/95~~ ~~c. Not be a facility operated by the Department of Mental Health and Developmental Disabilities, as described in Section A.7. of Chapter XVI.~~

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10/03 ~~07/95~~ 2. Calculation of Medicaid High Volume Adjustments

a. Hospitals meeting the criteria specified in Section F.1. above shall receive a MHVA payment adjustment of $60.

~~07/95~~ b. For children's hospitals, as defined in Section C.1.e. of this Chapter, the payment adjustment calculated under Section F.2.a. above shall be multiplied by 2.0.

~~07/95~~ c. The amount calculated pursuant to Sections F.2.a. and F.2.b. above shall be adjusted ~~on October 1, 1993, and annually thereafter, by a percentage equal to the lesser of:~~ by the aggregate annual increase in the national hospital market price proxies (DRI) hospital coast index (from the most recent publication of Health-Care Cost Review, published by Clobal Insight, located at 24 Hartwell Avenue, Lexington, MA) from the MHVA rate period-1993, as defined inF.4.b, through the MHVA rate period 2003, and annually thereafter, by a percentage equal to the lesser of:

i. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent twelve month period for which data are available; or

07/95 ii. The percentage increase in the statewide average hospital payment rate, as described in Section F.4.c. of this Chapter, over the previous year's statewide average hospital payment rate.

07/95 d. The adjustments calculated under Sections F.2.a. through F.2.c. of this Chapter shall be paid on a per diem basis and shall be applied to each covered day of care provided.

3. Medicaid High Volume Adjustment Limitations.

10/03 Hospitals that qualify for MHVA adjustments under Sections F.2.a. through F.2.c. above shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a ~~DSH~~ Medicaid Percentage Adjustment hospital, as required by Section F.1.a. In this instance, the annual adjustment described in Sections F.2.a. through F.2.c. shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for ~~DSH~~ Medicaid percentage adjustment payments~~payment adjustments~~, under Section C. of this Chapter, by the Department.

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07/95 4. Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by Section F. are as follows:

07/95 a. "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.

07/95 b. "MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

07/95 c. "Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section B. of Chapter VIII.

10/03 G. Medicaid Percentage Adjustments

1. 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:

i. The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section C.8.d, is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section C.8.c.

ii. The hospital's 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.

iii. Illinois hospitals that, on July 1, 1991, had a Medicaid inpatient utilization rate, as defined in Section C.8.d., that was at least the mean Medicaid inpatient utilization rate, as defined in Section C.8.c., and which 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 CRF, 5, 1989).

iv. Illinois hospitals that:

A. Have a Medicaid inpatient utilization rate, as defined in Section C.8.d., which is at least the mean Medicaid inpatient utilization rate, as defined in Section C.8.c., and

B. Also have a Medicaid obstetrical inpatient utilization rate, as defined in Section G.9.c., that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in Section G.9.b

v. Any children's hospital, as defined in Chapter II.C.3.of this Attachment.

vi. Out of state hospitals meeting the criteria in section C.5.

b. In making the determination described in subsection In making the determination described in subsections G.1.a.i and G.1.a.iv. of this Section, the Department shall utilize the data described in Section C.3 and received in compliance with Section C.6

c. Hospitals may apply to become a qualified Medicaid Percentage Adjustment hospital under subsection G.1.a.ii of this Section by submitting audited certified financial statements as described in Section C.4 and received in compliance with Section C.6

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d. Medicaid Percentage Adjustment for Hospitals defined in Chapter XVI,Sections A.1. and A.2., excluding hospitals defined in Section A.1.a.i. of Chapter XVI.

i. The payment adjustment shall be calculated based upon the hospital's Medicaid inpatient utilization rate, as defined in Section C.8.d. of this Chapter, and subject to Sections G.1.e. and G.1.f. of this Chapter, as follows:

A) Hospitals with a Medicaid inpatient utilization rate below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;

B) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

C) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

D) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

ii. For hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., the amount calculated pursuant to Section G.1.d. above shall be increased by $60 per day.

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iii. The Medicaid percentage adjustment payment, calculated in accordance with this Section, to a hospital, other than hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., shall not exceed $155 per day for a children's hospital, as described in Chapter II Section C.3. of this Chapter, and shall not exceed $215 per day for all other hospitals.

iv.. The amount calculated pursuant to Section G.1.d.i-iii. above shall be adjusted on October 1, 1993, 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 Section G.1.h.v. of this Chapter, over the previous year's statewide average hospital payment rate.

v. The amount calculated pursuant to G.1.d.i through G.1.d.iv. of this Chapter as adjusted pursuant to Sections G.1.e and G.1.f. shall be the inpatient payment adjustment in dollars for the applicable Medicaid Percentage determination year. The adjustments calculated under Sections G.1.d.i through G.1.d.iv. of this Chapter shall be paid on a per diem basis and shall be applied to each covered day of care provided.

~~d.~~ e. Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Chapter II.C.3. of this Chapter, the payment adjustment calculated under Section G.1.d.i. above shall be multiplied by 2.0.

f Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital organized under the University of Illinois Hospital Act, as defined in Section A.1.a.ii. of Chapter XVI., the payment adjustment calculated under Section G.1.d.i.. above shall be multiplied by 1.50.

g. MedicaidPercentage Adjustment Limitations.

i. 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 Chapter 2 Section C 1-4, must submit a statement to that effect.

ii. 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.1.g.ii. shall not apply to those hospitals described in Chapter 2 Section C 1-4 or those hospitals that have not offered nonemergency obstetrical services as of December 22, 1987. In this instance, the adjustments calculated under subsection G.1.d shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.

iii. Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Chapter XIV, Section C, which result in a change in a hospital's eligibility for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for Medicaid Percentage payment adjustments based upon the requirements of this Section.

iv. 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 C.8.d is less than one percent

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h. Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:

i. "Medicaid Percentage determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

ii. "Mean Medicaid obstetrical inpatient utilization rate " means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in Section C.8.g. below, 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 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in Section C.8.i. below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

iii. "Medicaid obstetrical inpatient utilization rate " means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in Section G.1.h.iv. below, 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 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in Section C.8.i. below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

iv. "Medicaid (Title XIX) obstetrical inpatient days" means, hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, with a Diagnosis Related Group

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(DRG) of 370 through 375), and specifically excludes Medicare/Medicaid crossover claims.

v. "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

vi. "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, which were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

vii. "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.

10/03 HG. Inpatient Payment Adjustments Based Upon Reviews

Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in Sections E. and F. of this Chapter, or their payment adjustment amounts, in accordance with Chapter IX., which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of Section E. and F. of this Chapter.

10/03 IH. Reductions to Total Payments

07/95 1. Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance medical program, and shall be assessed in accordance with the Chapter.

07/95 2. Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability

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of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

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IX. Review Procedure

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A. Inpatient Rate Reviews. Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of the rate for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of their rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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

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C. Disproportionate Share,DSH, and Medicaid Percentage Adjustment, MPA, Determination Reviews.

Hospitals shall be notified of their qualification for DSH and/or MPA payment adjustments and shall have an opportunity to request a review of the DSH and/or add-on for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of its DSH and/or MPA qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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10/03 1. DSH and/or MPA determination reviews shall be limited to the following:

10/03 a. DSH and/or MPA Determination Criteria. The criteria for DSH determination shall be in accordance with Section C. of Chapter VI. The criteria for MPA determination shall be in accordance with Section G.. Review shall be limited to verification that the Department utilized criteria in accordance with federal and State regulations.

b. Medicaid Inpatient Utilization Rates.

i. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section C.8.de. of Chapter VI. Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

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ii. Hospitals' Medicaid inpatient utilization rates, as defined in Section C.8.de, which have been derived from unaudited cost reports or HDSC forms, are not subject to the Review Procedure with the exception of errors in calculation by the Department. Pursuant to Section C.3.a.ii, C.3.a.iii.A), and C.3.a.iii.B), hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH and/or MPA determination.

c. Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act, ~~and~~ Sections C.1.b. and C.4. of Chapter VI. and Section G.1.a.ii and G.1.c of this State Plan. Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.

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10/03 d. Federally Designated Health Professional Shortage Areas (HPSA's). Illinois hospitals located in federally designated HPSA's shall be identified in accordance with 42 CFR 5, 1989, and Section G1.a.iii.of this State Plan based upon the methodologies utilized by, and the most current information available to the Department from the Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSA's only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of June 30, 1992.

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10/03 e. Excess Beds. Excess bed information shall be determined in accordance with Section G.1.a.iii and Section C.1.c. of Chapter VI. of this State Plan based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.

10/03 f. Medicaid Obstetrical Inpatient Utilization Rates . Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with G.1.a.iv and G.1.h.ii-iv. of Chapter VI. Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.

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07/95 D. Outlier Adjustment Reviews . The Department shall make outlier adjustments to payment amounts in accordance with Chapter V. or Section F. of Chapter VIII., whichever is applicable. Hospitals shall be notified of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation only. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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07/95 E. Cost Report Reviews. Cost reports are required from: 1) all enrolled hospitals within the State of Illinois; 2) all out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and 3) all hospitals not located in Illinois that elect to be reimbursed under the DRG PPS. The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days of the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report which may contain adjustments and revisions which may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis which support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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07/95 F. Trauma Center Adjustment Reviews .

07/95 1. The Department shall make trauma care adjustments in accordance with Section E. of Chapter VI. Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation.

10/93 2. Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.

10/93 3. Appeals under this Section must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for reiew.

07/95 G.Medicaid High Volume Adjustment Reviews. The Department shall make Medicaid high volume adjustments in accordance with Section F. of Chapter VI. Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

07/95 H. Sole Community Hospital Designation Reviews. The Department shall make sole community hospital designations in accordance with Section B. of Chapter VI. Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the

review no later than 30 days after receipt of the hospital's request for review.

07/95 I. Geographic Designation Reviews

07/95 1. The Department shall make rural hospital designations in accordance with Section B.3. of Chapter XVI. Hospitals have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be made in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

2. The Department shall make urban hospital designations in accordance with Section B.4. of Chapter XVI. Hospitals have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be made in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

J. Safety Net Hospital Adjustment Payment Reviews.

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