STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

4. If any of the services are determined to be non-covered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

07/95 5. For the rate periods described in Section B.2.of Chapter XVI, the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers.

09/91 D. Payment for Extraordinarily High Cost Day Outliers

If a discharge qualifies for an additional payment under the provisions of both Sections B. and C. of this Chapter, the additional payment is the greater of the following:

1. The payment computed under Section B. of this Chapter.
2. The payment computed under Section C. of this Chapter.

10/93 E. Outlier Payment Limitation. Notwithstanding any other provisions of this Chapter, the total reimbursement paid by the Department for a claim qualifying for an outlier payment under this Chapter shall not exceed the total covered inpatient charges.

07/05 F. Notwithstanding the provisions of this Chapter, payment for outlier cases shall be determined by using the following factors that were in effect on June 30, 1995:

1. The marginal cost factor (see Chapter XVI (B)(7)),
2. The Metropolitan Statistical Area (MSA) wage index (see Chapter VI(C)(2)),
3. The Indirect Medical Education (IME) factor (see Chapter VIII A 2(a)(i)(B)(4)),
4. The cost to charge ratio (see Chapter V(C)(3), and
5. The cost outlier threshold, (see Chapter XVI (B)(8)) where
   a. For admissions on or after December 3, 2001, through June 30, 2005, the cost outlier threshold multiplied by 1.22.

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   b. For admission on of after July 1, 2005, through December 31, 2007, the cost outlier threshold multiplied by 1.40.

   c. For admission on or after January 1, 2008, the cost outlier multiplied by 1.64.

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07/95 2. For inpatient services provided on or after October 1, 1992, the Department shall make outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for infants who have not attained the age of one (1) year, and to children who have not attained the age of six (6) years, and who receive such services in a disproportionate share hospital described in Section C.1.a through C.1.e of Chapter VI. The Department is not required to provide outlier adjustments for exceptionally long lengths of stay as there are no durational limits on inpatient stays and the Department reimburses the hospital on a per diem or per day basis regardless of the length of stay as long as such stay was medically necessary. The determination of those services qualified for an outlier adjustment shall be made as follows for services provided on and after October 1, 1992, and for each subsequent rate period, as defined in Section B.2.b. of Chapter XVI, for hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Chapter X.:

10/92 a. The services must have been provided on or after October 1, 1992; and

b. The services must have been provided to:

10/93 i. Children who have not attained the age of six (6) years by hospitals defined by the Department as DSH hospitals under Sections C.1.a through C.1.e of Chapter VI; or

10/93 ii. Infants who have not attained the age of one (1) year by hospitals that do not meet the definition of a DSH hospital under Section C.1.a. through C.1.e. of Chapter VI.

01/08 iii. Children who have not attained 19 years of age on the date of admission, for dates of service provided by a hospital devoted exclusively to the care of children under Section C.3.a., of Chapter II.

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10/93 i. For hospitals that do not meet the definition of a DSH hospital under Sections C.1.a.through C.1.e of Chapter VI in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and

10/93 ii. For hospitals defined by the Department as DSH hospitals under Sections C.1.a.throughC.1.e.of Chapter VI .in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of six years.

d. "Rate for services provided" means the inpatient rate in effect for the type of services provided.

10/93 e. "Total covered charges" means the amount entered on the ~~UB-82 or~~ UB-92 or UB04 Uniform Billing Form for revenue code 001 in column 53 (Total Charges).

07/05 4. Notwithstanding the provisions of subsection F of this Section, payment for outlier adjustments provided for exceptionally costly stays pursuant to Chapter VIII shall be determined as follows:

a. For admissions on or after December 3, 2001, through June 30, 2005, a factor of 0.22 in place of the factor 0.25 as described at Chapter VIII (F)(2)(c)(iv).

01/08 b. For admissions on or after July 1, 2005, through December 31, 2007, a factor of 0.20 as described at Chapter VIII (F)(2)(c)(iv).

01/08 c. For admissions on or after January 1, 2008, a factor of 0.17 in place of the factor 0.18 as described at Chapter VIII (F)(2)(c)(iv).

09/91 G. Filing Cost Reports

07/95 1. All hospitals in Illinois, those hospitals in contiguous states, providing 100 or more inpatient days of care to Illinois program participants, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the DRG PPS, shall be required to file Medicaid cost reports within 150 days of the close of the provider's fiscal year and submit a copy of the filed Medicare report.

07/95 2. No extension of the due date will be granted by the Department.

10/93 3. ~~The a~~Assessment or license fees mandated by law ~~*Public Acts 87-13, 87-861, and 88-88*~~ may ~~not~~ be reported as allowable ~~Medicaid~~ costs on the Medicaid cost report.

10/93 4. For a hospital that is electing to participate in the Illinois Medicaid Program and has not filed a Medicaid cost report before, the hospital must submit the two most recently audited Medicare cost report at the time of enrollment.