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State/Territory Name: IL

State Plan Amendment (SPA) #: 009-002

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

Center for Medicaid, CHIP, and Survey & Certification

OCT 18 2010

Ms. Julie Hamos, Director
Illinois Department of Health Care and Family Services
201 South Grand Avenue East
Springfield, Illinois 62763-0002

RE: Illinois 09-02

Dear Ms. Hamos:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-02. Effective for services on or after April 1, 2009, this amendment makes revisions to inpatient hospital rates and methodologies.

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 implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-02 is approved effective April 1, 2009. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (608) 441-5344.

Sincerely,

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

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: **09-02**

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: **April 1, 2009**

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:
Section 1902 of the *Social Security Act*

7. FEDERAL BUDGET IMPACT

a. FFY	**2009**	**$**	**14.0 million**
b. FFY	**2010**	**$**	**18.0 million**

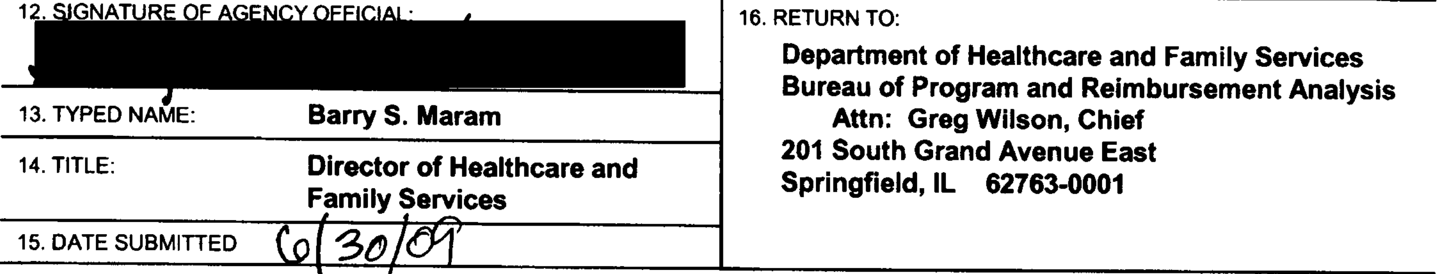
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19A
Attachment ~~4.19-B~~ pages 46, 77, 78, 80, 126, 126A, 127, 131B2, 131D1, 131G, 131H, 131L, 131M, 156, 157

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19A
Attachment ~~4.19B~~ pages 46, 77, 78, 80, 126, 126A, 127, 131B2, 131D1, 131G, 131H, 131L, 131M

10. SUBJECT OF AMENDMENT:
Hospital inpatient payment adjustments

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:

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

14. TITLE: **Director of Healthcare and Family Services**

15. DATE SUBMITTED: 6/30/09

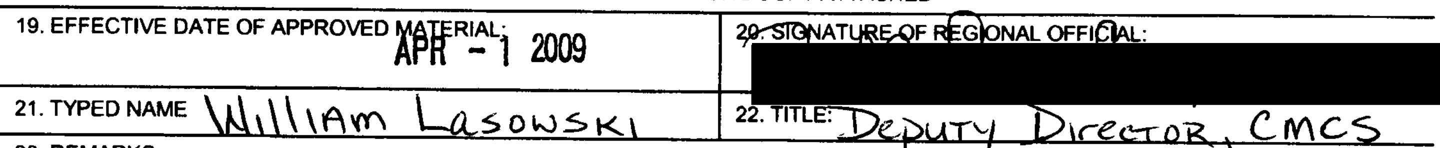
16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Greg Wilson, Chief
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 10-18-10

PLAN APPROVED—ONE COPY ATTACHED



19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:
10/18/10 P&I change made to boxes 8 and 9 at state's request. Changes revise 179 to reflect the proper section of plan being amended.

FORM CMS-179 (07/92)

Instructions on Back

~~10/93~~04/09

b. The information required in Section C.2 must be received within 30 calendar days of receipt of notification from the Department that the information must be submitted. Information required in this section, ~~which~~that 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~~04/09

a. Five Million Dollar Fund Adjustment for Hospitals Defined in Chapter XVI, Sections A.1 and A.2, with the exception of any Illinois hospital that is owned or operated by the State or a unit of local government.

10/93

i. Hospitals qualifying as DSH hospitals under Section C.1.a, 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., and hospitals qualifying as DSH hospitals under Section C.1.b. of this Chapter will receive an add-on payment to their inpatient rate.

10/93

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.

3. In the case of a new hospital (not previously owned or operated), a hospital that has changed its case-mix profile so that it meets the definition of a long term stay hospital in Section C.4. of Chapter II, or an out-of-state non-cost-reporting hospital, reimbursement for inpatient services shall be as follows:

07/07 a. For general acute care hospitals, reimbursement for inpatient services:

i. Provided before July 1, 2007, shall be at the average payment rate calculated under Chapter VIII. B.1 or B.2 for those hospitals that would otherwise be reimbursed under the DRG PPS.

ii. Provided on or after July 1, 2007, at the request of the hospital, shall be at either

04/09 A. The Federal/Regional blended rate described in Chapter IV. B 2 and, for dates of service provided on or after May 18, 2009, a capital rate equal to one standard deviation above the mean capital rate, as determined in Section C of Chapter VII, for all providers reimbursed under the same federal/regional blended rate, or

B. The average payment rate calculated under Chapter VIII.B.1 or B.2 for those hospitals that would otherwise be reimbursed under the DRG PPS.

iii. Provided by out of state hospitals shall be at the average payment rate calculated under Chapter VIII.B.1 or B2, as applicable, for those hospitals that would otherwise be reimbursed under the DRG PPS.

04/09 b. For psychiatric hospitals, as defined in Section C.1 of Chapter II:~~, reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section A.2 of this Chapter for those hospitals defined in Section C.1 of Chapter II.~~

i. For services provided on or after May 18, 2009, by a psychiatric hospital that began operation on or after January 1, 2008, that is devoted exclusively to the care of individuals who have not attained 19 years of age, reimbursement for inpatient psychiatric services shall be at the arithmetic mean of the rates defined in Sections B.3.b.ii and B.3.e.i of this Chapter.

ii. For all other psychiatric hospitals, reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section A.2 of this Chapter for those hospitals defined in Section C.1 of Chapter II.

c. For rehabilitation hospitals, as defined in Section C.2 of Chapter II, reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section A.2 of this Chapter for those hospitals defined in Section C2 of Chapter II.

d. For long term stay hospitals, as defined in Section C.4.of Chapter II, reimbursement for inpatient services shall be at the average rate calculated under Section A.2 of this Chapter for those hospitals defined in Section C.4 of Chapter II.

07/98 e. For children's hospitals, as defined in Section C.3.of Chapter II, reimbursement for inpatient services:

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

07/98 i. Provided before August 1, 1998, shall be at the average rate calculated under subsection B.1; or

ii. Provided on or after August 1, 1998, for a children's hospital that was licensed as such by a municipality after June 30, 1995, shall be equal to the average rate calculated in Chapter VIII.C.2.for children's hospitals in existence before June 30, 1995, with an average length of stay that was less than 14 days as determined from the hospital's fiscal year 1994 cost report.

09/91 C. Children's Hospitals

10/93 1. Initial Rate Period

10/93 a. For purposes of reimbursement, all children's hospitals, as defined in Section C.3 of Chapter II, are grouped into one peer group.

10/93 b. Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.

10/92 c. These base year costs shall be updated, trended forward, from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set according to the methodology of the national total hospital market basket price proxies, (DRI).

10/92 d. The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as its final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.

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)

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.

04/09 iv. Children who have not attained 19 years of age on the date of admission, for dates of service provided, on or after July 1, 2009, by a hospital devoted exclusively to the care of children under Section C.3.b., of Chapter II.

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

d. 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.

04/05

2. Hospitals qualifying under subsection C.1.a. of this Chapter will also receive the following rates:

a. County owned hospitals as defined in Section C.8 of Chapter II, with more 30,000 Total days will have their rate increased by $455.00 per day.

04/09

b. Hospitals that are not a county owned with more than 30,000 total days will have their rate increased by ~~$330.00~~ $354.00 per day for dates of service on or after April 1, 2009.

c. Hospitals with more than 80,000 Total days will have their rate increased by an additional $423.00 per day.

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

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

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

04/09

g. Hospitals with an average length of stay less than 3.9 days will have their rate increased by ~~$41.00~~$131.00 per day for dates of service on or after April 1, 2009.

04/09

h. Hospitals with a MUIR 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~~$360.00 per day for dates of service on or after April 1, 2009.

~~07/06~~04/09

i. Hospitals receiving payments under subsection (D)(1)(b) that have an average length of stay less than 4 days will have their rate increased by ~~$528.00~~$650.00 per day for dates of service on or after April 1, 2009.

07/06

j. Hospitals receiving payments under subsection (D)(1) that have a MIUR greater than 60 percent will have their rate increased by $320.50 per day.

04/09

k. Hospitals receiving payments under subsection (D)(1)(d) that have a Medicaid inpatient utilization rate greater than 70 percent and have more than 20,000 days will have their rate increased by ~~$98.00~~$185.00 per day for dates of service on or after April 1, 2009.

07/06

l. 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.

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)

3. Hospitals qualifying under subsection C.1.b. of this Chapter will receive the following rates:

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

04/09

   b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by ~~$369.00~~$600.00 per day for dates of service on or after April 1, 2009 through June 30, 2010. For dates of service on or after July 1, 2010, the rate is $369.00.

07/02

4. Hospitals qualifying under subsection C.1.c. of this Chapter will receive the following rates:

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

   b. Hospitals located in Illinois and outside of HSA 6 that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $55.00 per day.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT**

c. Hospitals located in Illinois and inside HSA 6, that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by $573.00 per day.

07/05 d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by $32.00 per day for hospitals that have less than 4,000 total days; or $246.00 per day for hospitals that have greater than 4,000 total days but less than 8,000 total days; or $178.00 per day for hospitals that have greater than 8,000 total days.

01/06 e. Hospitals with more than 3,200 Total admissions will have their rate increased by $328.00 per day.

5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:

07/02 a. Hospitals will receive a rate of $41.00 per day.

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

~~07/06~~04/09 c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional ~~$110.25~~$191.00 per day for dates of service on or after April 1, 2009.

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

07/05 6. Hospitals qualifying under subsection C1.e above will receive $188.00 per day.

7. Hospitals qualifying under subsection C.1.f. of this Section will receive a rate of $55.00 per day.

12/08 8. Hospitals that qualify under subsection(c)(1)(G) of this Section will receive the following rates:

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

b. Hospitals with an MIUR greater than 19.75 percent will receive a rate of $69.00 per day.

10/03 9. Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of $268.00 per day.

07/08

r. The hospital meets all of the following criteria in the safety net base year:
   i. Does not already qualify under subsections ~~(n)(1)~~1(a) through ~~(n)(17)~~1(q) of this Section.
   ii. Located outside HSA 6.
   iii. Has an MIUR greater than 16 percent.
   iv. Has licensed beds greater than 475.
   v. Has an average length of stay less than 5 days.

s. The hospital meets all of the following criteria in the safety net base year:
   i. Provided greater than 5,000 obstetrical care days.
   ii. Has a Combined MIUR greater than 80 percent.

04/09

t. The hospital meets all of the following criteria in the safety net base year:
   i. Does not already qualify under subsections 1(a) through 1(s) of this Section.
   ii. Has a CMIUR greater than 28 percent.
   iii. Is designated a perinatal Level II center by the Illinois Department of Public Health.
   iv. Has licensed beds greater than 320.
   v. Had an occupancy rate greater than 37 percent in the safety net hospital base year.
   vi. Has an average length of stay less than 3.1 days.

~~02/08~~04/09

2. The following five classes of hospitals are ineligible for safety net hospital adjustment payments associated with the qualifying criteria listed in 1(a) through 1(d), 1(f) through 1(h), 1(j) through 1(p), and 1(r)~~, and 1(s)~~through 1(t) of this section:
   a. Hospitals located outside of Illinois.
   b. County-owned hospitals, as described in Section A.1.a.i. of Chapter XVI.
   c. Hospitals organized under the *University of Illinois Hospital Act*, as described in Section A.1.a.ii. of Chapter XVI.

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)

07/08 g. For a hospital qualifying under subsection (1)(g) of this Section, the rate is $210.50.

07/06 h. For a hospital qualifying under subsection (1)(h) of this Section, the rate is $124.50.

07/06 i. For a hospital qualifying under subsection (1)(i) of this Section, the rate is $85.50

07/08 j. For a hospital qualifying under subsection (1)(j) of this Section, the rate is $13.75.

~~07/06~~04/09 k. For a hospital qualifying under subsection (1)(k) of this Section, the rate is $200.00 for dates of service on or after April 1, 2009 through June 30, 2010. For dates of service on or after July 1, 2010, the rate is $39.50.

07/08 l. For a hospital qualifying under subsection (1)(l) of this Section, the rate is $240.50.

07/08 m. For a hospital qualifying under subsection (1)(m) of this Section, for dates of service on or after April 1, 2009, the rate is $815.00.~~$231.50~~

07/08 n. For a hospital qualifying under subsection (1)(n) of this Section, the rate is $445.75.

07/08 o. (Reserved.)

02/08 p. For a hospital qualifying under subsection (1)(q) of this Section, the rate is $39.50.

07/08 q. For a hospital qualifying under subsection (1)(r) of this Section, the rate is $69.00.

07/08 r. For a hospital qualifying under subsection (1)(s) of this Section, the rate is $16.00.

04/09 s. For a hospital qualifying under subsection (1)(t) of this Section, for dates of service on or after April 1, 2009, the rate is $145.00.

4. Payment to a Qualifying Hospital

a. The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by two multiplied by total days.

07/08 b. Total payments will equal the sum of amounts calculated under the methodologies described in this subchapter K and shall be paid to the hospital during the safety net adjustment period in installments on, at least, a quarterly basis.

L. Tertiary Care Payments

Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals as described in Chapter II.C.8 and hospitals organized under the University of Illinois Hospital Act, as described in Chapter II.C.8 for inpatient admissions occurring on or after July 1,2002, in accordance with this Section.

a. Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:

1. "Base Period Claims" means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department though December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in Chapter II.C.3.a, be billed by a children's hospital shall be attributed exclusively to the children's facility. Base Period Claims shall exclude the following types:

   i. Claims for which Medicare was liable in part or in full (cross-over" claims)

   ii. Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and

   iii. Claims for services billed under categories of service 037 and 038 (exceptional care services)

04/09 b. "Case Mix Index" or "CMI"~~(CMI)~~, for all hospitals qualifying under this subpart K, means the sum of all Diagnosis Related Grouping (DRG)(see Chapter I.F.) Weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims.

i. Reimbursed under a per diem methodology; and

ii. For Delivery or Newborn Care.

04/09 c. "Case Mix Adjustment Factor" or "CMAF" ~~("CMA")~~ means the following:

i. For qualifying hospitals located in Illinois that, for Base Period Claims, had a CMI that is greater than the mean:

a. CMI of all Illinois cost-reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.040;

b. CMI plus one stand deviation above the mean of all Illinois cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.250;

c. CMI plus two standard deviations above the mean of all Illinois cost reporting hospitals, the CMAF shall be equal to 0.300

ii. For qualifying hospitals located outside of Illinois that, for Base Period Claims, had a CMI that is greater than the mean:

A. CMI of all out-of-state cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.020;

B. CMI plus one standard deviation above the mean of all out-of-state cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.125;

C. CMI plus two standard deviations above the mean of all out of state cost reporting hospitals, the CMAF shall be equal to 0.150.

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

a. Qualifying Hospital. A long term stay hospital, as defined in Chapter II.C.4 that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, shall qualify for this payment

b. Qualified Days. For the purposes of this subsection (6), Qualified Day means a day of care that was provided in a Base Period Claim, excluding claims billed to the Department under category of service of 021 (hospital inpatient psychiatric services) or 022(hospital inpatient physical rehabilitation services)

c. Long Term Stay Hospital Rates. A Qualifying Hospital will receive payments equal to the product of:

i. The number of Qualified Days from all Base Period Claims; and

04/09 iid. A constant that

Ai. for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, $3,000.00$300; or

Bii. for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, but less than one standard deviation above that mean, $5.

7. Rehabilitation Hospital Adjustment - The Department shall make a Rehabilitation Hospital Adjustment to certain hospitals as defined in this subsection (7).

a. Qualifying Hospital. A hospital that qualifies for the Rehabilitation HospitalAdjustment under the Critical Hospital Adjustment Payments (CHAP) program, as defined in Chapter XV, shall qualify for this payment.

b. Qualified Admission. For the purposes of this subsection (7), Qualified Admission shall mean a Medicaid level I rehabilitation admission in the CHAP rate period, as defined in Chapter XV.B, for fiscal year 2001.

c. Rehabilitation Hospital Adjustment. A Qualifying Hospital shall receive payment as follows:

i. For a hospital that had fewer than 60 Qualified Admissions, $100,000.

ii. For a hospital that had 60 or more Qualified Admissions, $350,000.

8. Tertiary Care Adjustment

   i. The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (2) through (7) of this Section multiplied by 0.455.

   ii A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.

04/09 iii. For hospitals qualifying for payments under this Section for the adjustment period beginning April 1, 2009, total payments will equal the sum of the amounts calculated under the methodologies described in this Section less the Tertiary Care Adjustment amounts received from July 1, 2008 through March 31, 2009.

M. Psychiatric Adjustment Payments

1. Qualifying criteria: Psychiatric adjustment payments shall be made to a qualifying hospital, as defined in this subsection (1). A hospital not otherwise excluded under subsection (2) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:

   a. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in (5)(e) greater than 60 percent.

   b. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 20 percent; has greater than 325 total licensed beds as described in (5)(b); and has a psychiatric occupancy rate described in (5)(d), greater than 50 percent.

   c. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 15 percent; has greater than 500 total licensed beds as described in (5)(b); has a psychiatric occupancy rate as described in (5)(d) greater than 35 percent; and has total licensed psychiatric beds described in (5)(c) greater than 50.

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)

04/09 XXXI. Catastrophic Relief Payments

A. Qualifying Criteria. Catastrophic Relief Payments, as described in this section, shall be made to Illinois hospitals, except publicly owned or operated hospitals or a hospital identified under Section C.3.b of Chapter II, that have an MIUR greater than the current statewide mean, are not a publicly owned hospital, and are not part of a multiple hospital network, unless the hospital has an MIUR greater than the current statewide mean plus two standard deviations. Payments to qualifying hospitals will be based on criteria described in this Section.

B. Payments.

1. An Illinois hospital qualifying under subsection a. of this Section that is a general acute care hospital with greater than 3,000 Medicaid admissions, and a case mix greater than 70%, will receive the greater of:

   a. Medicaid admissions multiplied by $2,250; or

   b. $8,000,000.

2. Payments under this Section are effective for State fiscal year 2009. Payments are not effective for dates of service on or after July 1, 2009.

C. Definitions

1. "MIUR" means Medicaid inpatient utilization rate as defined in Section C.8.e of Chapter VI. For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2009 shall be the same determination used to determine a hospital's eligibility for Catastrophic Relief Payments in the Adjustment Period.

2. "General acute care hospital: is a hospital that does not meet the definition of a hospital ascribed in Section C. of Chapter II.

3. "Case mix index" means, for a given hospital, the quotient resulting from dividing the sum of all the diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Chapter X., by the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Chapter X.

4. "Medicaid admissions" means State fiscal year 2007 hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the 2009 CHAP rate period, as defined in Section II.3 of Chapter XV., and contained within the Department's paid claims database, for recipients of medical assistance under Title XIX of the Social Security Act, excluding Medicare/Medicaid crossover admissions.

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

State: **Illinois**

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D. Rate reviews.

1. A hospital shall be notified in writing of the results of the payment determination pursuant to this Chapter.

2. Hospitals shall have a right to appeal pursuant to the provisions of Section C.2 of Chapter XXI.