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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 non-emergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals described in Sections C.1 throughC.4 of Chapter II, must submit a statement to that effect. "Obstetric services" shall at minimum include non-emergency inpatient deliveries in the hospital.

10/92

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.e 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.

07/08

f. DSH for government-owned or -operated hospitals.

i. The following classes of government-owned or -operated Illinois hospitals shall, subject to the limitations set forth in subsection g of this section, be eligible for disproportionate share hospital adjustment payment:

A. Hospitals defined in paragraph A.1.a.i of Chapter XVI.

B. Hospitals owned or operated by a unit of local government that is not a hospital defined in subparagraph A above.

C. Hospitals defined in paragraph A.1.a.ii of Chapter XVI.

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ii. The annual amount of the payment shall be the amount computed for the hospital pursuant to subparagraph g.iv.B of this section, adjusted from the midpoint of the cost report period to the mid-point of the rate period using the CMS Hospital Price Index. For LARGE PUBLIC HOSPITALS, as defined in Chapter XXI, the adjustment factor will be the average annual growth in each hospital's cost per diem. The average annual growth shall be calculated as follows:

A. Inpatient average cost per diems are calculated using Medicaid claims data from two sets of fiscal years that are two years apart. Costs are determined in accordance with the methodology in Chapter XXX., Section D.1.

B. An average annual increase is calculated based on the percentage change in the average inpatient cost per diems over the two year time period.

C. The fiscal years used to determine the average annual growth will be updated annually. For example, the fiscal year 2011 rate trend factors are based upon cost per diem information from fiscal years 2006 and 2008; while fiscal year 2012 factors will be based upon cost per diem information from fiscal years 2007 and 2009.

iii. The annual amount shall be paid to the hospital in monthly installments. That portion of the annual amount not paid pending approval of this State plan amendment (TN 08-06) shall, upon approval, be paid in a single lump sum payment. The annual amount shall be paid to the hospital in twelve equal installments and paid monthly.

07/95

g. DSH Adjustment Limitations.

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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 non-emergency obstetric services as of December 22, 1987). In this instance, the adjustments calculated under Sections C.7.a ~~and~~ through C.7.~~b~~f. shall cease to be effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care. "Obstetric services" shall at minimum include non-emergency inpatient deliveries in the hospital.

10/92

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.

07/08

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 Centers for Medicare and Medicaid Services, DSH payment adjustments calculated under this section shall be adjusted to meet the State DSH allotment. This adjustment shall be applied to satisfy the payments under this section in the follow order:

A. Payments made under subsection C.7.c.

B. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.i.C.

C. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.i.B.

D. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.a.

E. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.i.A.

F. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.b.

07/08 **XXX. Payment to government-owned or -operated hospitals.**

A. Definitions.

10/10 "BASE PERIOD" means the hospital fiscal year ending during the calendar year that is three ~~four~~ years prior to the calendar year during which the payment period begins.

"PAYMENT PERIOD" means the State fiscal year.

B. Notwithstanding any other provision of this Attachment, reimbursement to LARGE PUBLIC HOSPITALS shall be at allowable cost, as determined in section D of this chapter.

C. Hospitals that are located in Illinois and are owned or operated by a county or a unit of local government that are not LARGE PUBLIC HOSPITALS shall be reimbursed at the greater of:

1. Under the payment methodologies otherwise provided for in this Attachment.
2. At allowable cost, as determined in section D of this chapter.

D. Hospitals reimbursed under this chapter shall be reimbursed at allowable cost on a per diem basis. The per diem rate shall be calculated as follows:

1. BASE PERIOD costs are determined as the product resulting from multiplying (i) the routine and ancillary charges on claims that were submitted by the hospital for Medicaid covered services provided during the BASE PERIOD and paid by the department by (ii) their respective cost-to-charge ratios from the BASE PERIOD cost report.

2. BASE PERIOD costs are then adjusted by subtracting the sum of all periodic (weekly, monthly, quarterly, *etc.*) lump sum payments specified in this Attachment, with the exception of any payment that is classified as a disproportionate share hospital adjustment payment, that are expected to be made during the PAYMENT PERIOD.

3. For hospitals reimbursed under subsection C.2, the BASE PERIOD costs are additionally reduced by an amount necessary to ensure:

   a. That reimbursement to non-State government-owned or operated hospitals, as a class, is compliant with the upper payment limit requirement in 42 *CFR* 447.272.
   b. That the proportion of allowable costs that are reimbursed is the same for each hospital.

10/10 4. The BASE PERIOD costs are further adjusted to reflect the change, from the midpoint of the BASE PERIOD to the midpoint of the PAYMENT PERIOD, in the CMS hospital input price index. For LARGE PUBLIC HOSPITALS, as defined in Chapter XXI, the adjustment factor will be the average annual growth in each hospital's cost per diem. The average annual growth shall be calculated as follows:

   a. Inpatient average cost per diems are calculated using Medicaid claims data from two sets of fiscal years that are two years apart. Costs are determined in accordance with the methodology in this Section.

b. An average annual increase is calculated based on the percentage change in the average inpatient cost per diems over the two year time period.

c. The fiscal years used to determine the average annual growth will be updated annually. For example, the fiscal year 2011 rate trend factors are based upon cost per diem information from fiscal years 2006 and 2008; while fiscal year 2012 factors will be based upon cost per diem information from fiscal years 2007 and 2009.

5. The per diem rate is the quotient resulting from dividing the adjusted BASE PERIOD costs by the number of patient days on claims that were submitted by the hospital for Medicaid covered services provided during the BASE PERIOD and paid by the department.

OS Notification

State/Title/Plan Number:	**Illinois 10-007**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**April 12, 2012**
Fiscal Impact:	**FY 2011 $30,300,000** **FY 2012 $26,600,000**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: **Effective October 1, 2010, this amendment proposes to revise methodology for calculating DSH payments for large public hospitals; revises alternate payment methodology to government-owned or operated hospitals; revises the obstetrician requirement for purposes of eligibility for DSH payments. Funding the non-Federal share comes from a combination of State appropriations, provider tax, and IGT. The State met public process requirements. There are no issues with the UPL.**

The reason for the lengthy review time for this amendment was due to issues regarding how the state was going to calculate the inpatient hospital upper payment limit. Additionally, the amendment was off the clock for 6 months awaiting the State's responses to RAI questions.

This amendment would clarify the State's definition of the term "obstetrician", for hospitals located in a rural area, to include any physician with staff privileges to perform non-emergency obstetric procedures at the hospital. This amendment would also articulate that "obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

Illinois makes DSH payments to government-owned or operated hospitals, computed by determining a hospital's 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 the State plan. This amendment proposes that, for large public hospitals, the adjustment factor used as

part of this calculation will be the average annual growth in each hospital's cost per diem.

The State plan also provides for an alternate payment methodology for government-owned or operated hospitals, reimbursed at the greater of payment methodology elsewhere in the State plan or at allowable cost. Reimbursement to large public hospitals shall be at allowable cost, as determined under this alternate payment methodology. This amendment proposes that, for large public hospitals, the adjustment factor used as part of this calculation will be the average annual growth in each hospital's cost per diem.

Other Considerations: **This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.**

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

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National Institutional Reimbursement Team