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**State/Territory Name: IL**

**State Plan Amendment (SPA) #: 11-002**

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

August 28, 2015

Felicia F. Norwood, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: Teresa Hursey

RE: TN 11-02

Dear Ms. Norwood:

Enclosed for your records is an approved copy of the following State Plan Amendment:

| | |
|---|---|
| Transmittal #11-02 | --Revises the reimbursement methodology for outpatient supplemental payments, critical access hospitals, off-site clinics, and free standing emergency centers.<br>--Effective Date: January 1, 2011 |

If you have any questions, please have a member of your staff contact Courtenay Savage at 312-353-3721 or by email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sara Barger, HFS
Mary Doran, HFS

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 | 2. STATE: |
|---|---|
| 11-02 | 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:
**January 1, 2011**

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 **2011** **$ 15.9 million**
b. FFY **2012** **$ 18.3 million**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
**Attachment 4.19-B pages 1, 12, 13, 19, 31C, 51, 52, 54**
~~**Appendix to Attachment 3.1-A pages 1(A)(8), 1(A)(9), 1(A)(10)**~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
**Attachment 4.19B pages 1, 12, 13, 19, 31C, 51, 52, 54**
~~**Appendix to Attachment 3.1-A pages 1(A)(8), 1(A)(9), 1(A)(10)**~~

10. SUBJECT OF AMENDMENT:
Outpatient supplemental payments, Critical Access Hospital payments, Off-site clinics, Free-standing emergency centers

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: **Julie Hamos**

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

15. DATE SUBMITTED 3/31/11

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: 3/31/11

18. DATE APPROVED: 8/28/15

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07/92)

*Instructions on Back*

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

State: **Illinois**

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

10/92 1. Reimbursement for Hospital Outpatient and Clinic Services

a. Fee-For-Service Reimbursement

07/98 i. Reimbursement for hospital outpatient shall be made on a fee-for-service basis except for:

07/98 A. Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection b of this Section;

07/98 B. End Stage Renal Disease Treatment (ESRDT) services, as described in subsection c. of this Section;

07/98 C Those services provided by a Critical Clinic Provider as described in subsection e. of this Section;~~.~~

01/11 D. Effective January 1, 2011, ~~T~~those services provided by a Freestanding Emergency Center, as described in subsection j. of this Section.

07/99 ii. Except for the procedures under the APL groupings described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens, as described in the annual obstetric and pediatric State plan. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as non-hospital providers who bill fee-for-service.

07/95 B. In order to ensure funding for the outpatient indigent volume adjustment payment, an indigent pool shall be created. The amount of money dedicated to this pool shall equal $200 million.

07/95 C. Payments from the indigent pool, to individual eligible hospitals, shall be in an amount that is in proportion to the number of Medicaid outpatient services (as identified on claims submitted to the Illinois Department of Public Aid for payment) that the individual hospital provided to persons eligible for Medicaid divided by the total of all Medicaid outpatient services provided to persons eligible for Medicaid by all hospitals eligible to receive outpatient indigent volume adjustment payments. The service statistics used in this calculation shall reflect services provided during the most recently completed State fiscal year prior to the State fiscal year in which the payments are being made (SFY'94 utilization statistics for payments made in SFY'96). Payments under this subsection shall be made on a quarterly basis.

07/95 D. Aggregate Medicaid reimbursement for all hospitals for Medicaid outpatient services (including outpatient indigent volume adjustment reimbursement ) will not be allowed to exceed total allowable Medicaid outpatient costs for Medicaid outpatient services provided to Illinois Medicaid recipients. This test will be made annually. If the test against the upper limit finds that the upper limit was exceeded, the size of the outpatient indigent volume adjustment pool will be reduced by the amount in excess of the limit.

01/11 v. Critical Access Hospital Rate Adjustment

Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485, Subpart F shall be eligible for an outpatient rate adjustment for services identified in subsections 1.b.i.A—1.b.i.F., excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:

A. An annual distribution factor shall be calculated as follows;
   1. The numerator of which shall be $33 million.
   2. The denominator of which shall be the RY-2011 total outpatient cost coverage deficit calculated in accordance subsection 1.n., less the RY-2011 Rural Adjustment outpatient Payments calculated in accordance with subsection 1.n. plus the annual outpatient supplemental payment calculated in accordance with Section 32.

B. Hospital Specific Adjustment Value;
   For each hospital qualified under this subsection v., the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in subsection v.A.2. of this section and the distribution factor calculated in v.A. of this section.

C. Final APL Rate Adjustment Values shall be the quotient of;
   1. The Hospital Specific Adjustment Value identified in subsection v.B. of this Section divided by;

2. The total outpatient services identified in subsections 1.b.i.A—1.b.i.F. excluding services for Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the departments paid claims database as of December 31, 2010.

D. Non-State Government owned provider adjustment
Final APL rates for hospitals identified as Non-State government owned or operated providers in the state's Upper Payment Limits demonstration shall be monitored and prospective adjustments made when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.32104.

E. Applicability
The rates calculated in accordance with subsection v.A. of this Section shall be effective for dates of service beginning January 1, 2011and shall be adjusted each State fiscal year beginning July 1, 2011.

1. For State fiscal year 2011 the rate year shall begin January 1, 2011 and end June 30, 2011.
2. For State fiscal year 2012 and beyond the rate year shall be for dates of service beginning July 1 through June 30 of the subsequent year.
3. For purposes of this adjustment children's hospital identified in Attachment 4.19-A Chapter II.C.3.b., shall be combined with the corresponding general acute care parent hospital.
4. Beginning with State fiscal year 2012 and each subsequent state fiscal year thereafter, the adjustment to the FY-2011 final APL Rate adjustment shall be limited to 2%.

01/11
07/95 vi. No Year-End Reconciliation
With the exception of the retrospective rate adjustment described in 1.b.vi of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1.b.

01/11
07/95 vii. Rate Adjustments
With respect to those hospitals described in Appendix to Attachments 3.1A and 3.1B, Section 2a.9a.1, the reimbursement rates described in 1.b.iv above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A. The reimbursement rates described in 1.b.iv above shall be no less than the reimbursement 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.

B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

01/11 viii. Hospitals described in Appendix to Attachments 3.1A and 3.1B, Sections 2a.9a.1 and 2a.9a.2, shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.

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

State: **Illinois**

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

07/98 f. Special Reimbursement Requirements for Services Provided in Hospital Emergency Room and Clinic Settings.

~~i.~~ When emergency room services are provided to clients, the hospital is required to code any fee-for-service claims with the emergency room place of service.

07/03 g. Hospital-Based Organized Clinic Reimbursement.

i. With respect to hospital-based organized clinics that qualify as Maternal and Child Health Clinics, payment shall be made in accordance with Section 1(a) (iv) of this attachment.

ii. With respect to all other hospital-based organized clinics, payment shall be in accordance with the fee-for-service reimbursement described in Section 1 of this attachment.

07/03 h. Reserved.

07/98 i. Psychiatric clinic reimbursement

Reimbursement shall be made under the federally qualified health center methodology if the clinic meets the criteria as an FQHC. Otherwise the clinic shall be reimbursed as an encounter rate clinic

j. Freestanding Emergency Centers

A hospital owned or controlled Freestanding Emergency Center (FEC) that provides comprehensive emergency treatment services 24 hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Emergency Medical Services (EMS) Systems Act as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the EMS Systems Act in effect for the jurisdiction in which it is located, is eligible for reimbursement of emergency services. Reimbursement for the emergency services provided in an FEC shall be made at the applicable APL group rate identified in subsection b.i.C of this Section. Payment for salaried physician services performed in conjunction with an APL procedure shall be made in accordance with subsection b.ii.F of this Section.

10/05 3. Encounter Rate Clinic Reimbursement

a. For free-standing encounter rate clinics enrolled in the Medicaid program prior to July 1, 1998, that are not operated by a county with a population of over three million, payment shall be made at the lesser of the following for services on or after October 1, 2005:

i. $90.00 per encounter; or

ii. The clinic's charge to the general public.

01/11 b. For encounter rate clinics providing dental services as of January 1, 2011, payment shall be made at the lesser of:

i. $85 per encounter; or

ii. The clinic's historical annual cost per encounter as calculated for a Federally Qualified Health Center (FQHC) in accordance with the approved FQHC methodology used to determine a cost per encounter as described in Section 2(b)(i)(E)(2).

~~b~~c. For all other encounter rate clinics, payment shall be made at the lesser of:

i. The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

ii. $50.00 per encounter; or

iii. The clinic's charge to the general public.

01/11 d. Encounter rates shall be adjusted annually using the Medicare Economic Index (MEI) in accordance with Section 2(b)(iv)(B).

vii. A GENERAL ACUTE CARE HOSPITAL, not located in Cook County, that is a not trauma center, did not qualify for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Attachment 4.19-A, subsection VI.C.7.b, has a MIUR of greater than 25 percent, an EMERGENCY CARE PERCENTAGE greater than 50 percent, and provided more than 8,500 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

viii. A GENERAL ACUTE CARE HOSPITAL, not located in Cook County, that is a level I trauma center, recognized by the Illinois Department of Public Health as of July 1, 2006, an EMERGENCY CARE PERCENTAGE greater than 50 percent, and provided more than 16,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, including more than 1,000 NON-EMERGENCY SCREENING OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, in the OUTPATIENT ASSISTANCE BASE YEAR.

ix. A GENERAL ACUTE CARE HOSPITAL, not located in Cook County, that qualified for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Attachment 4.19-A, subsection VI.C.7.b, an EMERGENCY CARE PERCENTAGE greater than 55 percent, and provided more than 12,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, including more than 600 SURGICAL GROUP OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES and 7,000 reimbursed through methodologies described in subsection b.i.C of Chapter 1 of this attachment, in the OUTPATIENT ASSISTANCE BASE YEAR.

x. A GENERAL ACUTE CARE HOSPITAL that has an EMERGENCY CARE PERCENTAGE greater than 75 percent, and provided more than 15,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

xi. A rural hospital that has an has a MIUR of greater than 40 percent and provided more than 16,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

xii. A GENERAL ACUTE CARE HOSPITAL, not located in Cook county, that is a trauma center, recognized by the Illinois Department of Public Health as of July 1, 2006, had more than 500 licensed bed in calendar year 2005, and provided more than 11,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, including more than 950 SURGICAL GROUP OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, in the OUTPATIENT ASSISTANCE BASE YEAR.

12/09 xiii. A GENERAL ACUTE CARE HOSPITAL, located outside of Illinois, that provided more than 300 HIGH TECH DIAGNOSTIC MEDICAID OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, in the outpatient assistance base year.

01/11 xiv. A GENERAL ACUTE CARE HOSPITAL that is recognized as a Level I trauma center by IDPH on the first day of the OAAP rate period, has Emergency Level I services greater than 2,000, Emergency Level II services greater than 8,000, and greater than 19,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

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

State: **Illinois**

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

b. Outpatient Assistance Adjustment Payments

i. For hospitals qualifying under a.i., above the rate is $139.00

ii. For hospitals qualifying under a.ii., above the rate is $850.00.

iii. For hospitals qualifying under a.iii., above the rate is $425.00.

12/09 iv. For hospitals qualifying under a.iv., above the rate is $665.00, through June 30, 2012. For dates of service on or after July 1, 2012, the rate is $375.00.

v. For hospitals qualifying under a.v., above the rate is $250.00.

vi. For hospitals qualifying under a.vi., above the rate is $336.25.

vii. For hospitals qualifying under a.vii., above the rate is $110.00.

viii. For hospitals qualifying under a.viii., above the rate is $200.00.

01/11 ix. For hospitals qualifying under a.ix., above the rate is $128.50, through June 30, 2010 ~~2012~~. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $74.00 to $202.50. For dates of service on or after July 1, 2012, the rate is $48.50.

01/11 x. For hospitals qualifying under a.x., above the rate is $135.00. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $70.00 to $205.00.

xi. For hospitals qualifying under a.xi., above the rate is $65.00.

xii. For hospitals qualifying under a.xii., above the rate is $90.00.

12/09 xiii. For hospitals qualifying under a.xiii., above, that have an EMERGENCY CARE PERCENTAGE greater than 19%, but less than 25%, the rate is $141.00. For hospitals qualifying under a.xiii., above, that have an EMERGENCY CARE PERCENTAGE greater than 25%, the rate is $494.00.

01/11 xiv. For hospitals qualifying under a.xiv., the rate is $47.00 for dates of service on or after July 1, 2010 through June 30, 2012. For dates of service on or after July 1, 2012, the rate is $0.00.

c. Payment to a Qualifying Hospital

The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by the Medicaid outpatient ambulatory procedure listing services in the OUTPATIENT ASSISTANCE ADJUSTMENT BASE YEAR. For the outpatient assistance adjustment period for fiscal year 2011 and after, total payments will equal the amount determined using the methodologies described in this subsection. The annual amount of each payment for which a hospital qualifies shall be ~~made in twelve equal installments and paid monthly~~ paid, at least, on a quarterly basis.

vii. "GENERAL ACUTE CARE HOSPITAL" has the same meaning as the term so defined in Chapter XXI of Attachment 4.19-A.

ix. "LARGE PUBLIC HOSPITAL" has the same meaning as the term so defined in Chapter XXI of Attachment 4.19-A.

x. "MIUR" means Medicaid inpatient utilization rate as defined in subsection VI.C.8.e of Attachment 4.19-A.

12/09 xi. "HIGH TECH DIAGNOSTIC MEDICAID OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 1.b.i.B.2., excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.

01/11 e. For a hospital that is located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 *ILCS* 5/5-30, no new payment or rate increase that would otherwise be effective for dates of service on or after January 1, 2011, shall take effect under Chapter 31of this Attachment unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in Chapter XV.H.5. This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.

fe. Rate reviews.

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

ii. Hospitals shall have a right to appeal pursuant to the provisions of section XXI.C.2 of Attachment 4.19-A.