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.

01/08 b. For admission on of after July 1, 2005, through December 31, 2007, the cost outlier threshold multiplied by 1.40.

01/11 c. For admission on or after January 1, 2008, through December 31, 2010, the cost outlier multiplied by 1.64.

01/11 d. For admissions on or after January 1, 2011, the cost outlier threshold multiplied by 1.99.

i. If the sum of Medicaid trauma center admissions within either class, as described in subsection A.2.a., is equal to or greater than the mean Medicaid trauma admissions for the 2 classes under subsection A.2.a., of this Section, then each member of that class shall receive an adjustment of $5,250.00 per Medicaid trauma admission for that class, in the CHAP base period.

ii. If the sum of Medicaid trauma center admissions within either class, as described in subsection A.2.a., is less than the mean Medicaid trauma admissions of the 2 classes under subsection A.2.a., of this Section, then each member of that class shall receive an adjustment of $3,625.00 per Medicaid trauma admission for that class, in the CHAP base period.

07/07

3. Level II Rural Trauma Center Adjustment (TCA). Illinois rural hospitals, as defined in Chapter XVI B.3, that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period.

07/07

4. Level II Urban Trauma Center Adjustment (TCA). Illinois urban hospitals, as described in Chapter XVI B.4, that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health (IDPH) shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the following criteria:

   a. The hospital is located in a county with no Level I trauma center;

   b. The hospital is located in a Health Professional Shortage Area, as of the first day of July in the CHAP rate period and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in A.4.a of this Chapter or the hospital has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection A.4.a of this Chapter; and

   c. The hospital does not qualify under subsection A.2.

01/11

B. Rehabilitation Hospital Adjustment (RHA)

Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as free-standing acute comprehensive rehabilitation hospitals, as defined Section C.2 of Chapter II, and are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare Facilities), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following ~~three~~ four components:

07/02

1. Treatment Component. All hospitals defined in Section B. of this Chapter shall receive $4,215.00 per Medicaid Level I rehabilitation admission in the CHAP base period.

2. Facility Component. All hospitals defined in Section B. of this Chapter shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:

07/05

   a. Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $229,360.00 in the CHAP rate period

   b. Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $527,528.00 in the CHAP rate period.

07/02

3. Health Professional Shortage Area Adjustment Component. Hospitals defined in Section B. of this Chapter, that are located in an HPSA as of the first day of July in the CHAP rate period, shall receive $276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.

01/11

4. Magnet Facility Component. Hospitals defined in subsection B. of this Chapter that as of July 1, 2010, are designated as a "magnet hospital" by the American Nurses' Credentialing Center, will receive a magnet component of $1,500,000 for the period January 1, 2011 through June 30, 2011, and $1,500,000 for the period July 1, 2011 through June 30, 2012.

C. Direct Hospital Adjustment (DHA) Criteria

1. Qualifying Criteria

07/06

Hospitals may qualify for the DHA under this subsection under the following categories, unless the hospital did not provide Comprehensive emergency treatment services as defined in subsection 5(C) below, on or after July 1, 2006, but did provide such services on January 1, 2006, unless the hospital provider operates within 1 mile of an affiliate hospital provider, that is owned and controlled by the same governing body that operates a comprehensive emergency room and the provider operates a standby emergency room that functions as an overflow emergency room for its affiliate hospital provider.

a. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:

i. Were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999, and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;

ii. Were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999, and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii. Were county-owned hospitals as defined in Section C.8 of Chapter II, and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

b. Illinois Hospitals located outside of HSA 6 that have a MIUR greater than 60 percent on July 1, 1999, and an average length of stay less than ten days. The following hospitals are excluded from qualifying from this criteria: children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

c. Children's hospitals, as defined under Section II.C.3, on July 1, 1999.

d. Illinois Teaching hospitals with more than 40 graduate medical education programs, on July 1, 1999, not qualifying in subsections C.1.a, b. or c. of this Chapter.

01/11 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. For dates of service on or after January 1, 2011 through June 30, 2012, this rate shall be increased by an additional $47.00 to $620.00 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:

i. $32.00 per day for hospitals that have less than 4,000 total days; or

ii. $363.00 per day for dates of service through June 30, 2012, for hospitals that have greater than 4,000 total days but less than 8,000 total days; for dates of service on or after July 1, 2012, the increase is $246.00 per day; or

iii. $295.00 per day for dates of service through June 30, 2012, for hospitals that have greater than 8,000 total days; for dates of service on or after July 1, 2012, the increase is $178.00 per day.

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.

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

01/11 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. For dates of service on or after January 1, 2011 through June 30, 2012 this rate shall be further increased by $54.00 per day to $95.00 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 but equal to or less than 20.00 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.

i. One-half of this quarterly payment will be classified as DSH spending for federal reporting purposes.

ii. If the federal upper payment limit cap reduces spending by an amount that is greater than one-half the quarterly spending, the amount reclassified as DSH will be increased by the amount of the payment reduction that exceeded one-half of the original payment.

iii. The amount classified as DSH spending in subsection (1) or (2) will be constrained both by the available funding in the State's federal DSH allotment and the hospital specific OBRA test.

12. DHA Payments

a. Payments under this subsection D will be made at least quarterly, beginning with the quarter ending December 31, 1999.

b. Payment rates will be multiplied by the Total days.

c. Total Payment Adjustments

~~01/07~~01/11 ~~i.~~ For the CHAP rate period occurring ~~in State fiscal year 2007 total payments will equal the methodologies described above. For the period~~ January 1, ~~2007~~ 2011, to June 30, ~~2007~~ 2011, payments will equal the hospital's rate multiplied by Total days ~~State fiscal year 2006 amount~~ less the amount the hospital received under DHA for the quarters ending September 30, ~~2007~~ 2010 and December 31, ~~2007~~ 2010.

~~04/05~~01/11 ~~ii. For CHAP rate periods occurring after State fiscal year 2006, total payments will equal the methodologies described above.~~

d. Payments under this subsection D that are made to disproportionate share hospitals in accordance with Chapter VI.C.5.7 will be considered to be disproportionate share payments, until September 30, 2002 except for payments made to hospitals defined in Chapter XIII.

E. Rural Critical Hospital Adjustment Payments (RCHAP)

Rural Critical Hospital Adjustment Payments (RCHAP) shall be made to rural hospitals as subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179.00 per year. The Department shall also make a RCHAP adjustment payment to hospitals qualifying under this subsection at a rate that is the greater of:

1. The product of $1,367.00 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or

2. The product of $138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

F. Total CHAP Payment Adjustments—Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in sections A, B, C and E of this Chapter. The critical hospital adjustment payments shall be paid at least quarterly.

~~07/07~~01/11 G. Critical Hospital Adjustment Limitations.

1. Hospitals that qualify for trauma center adjustments under Section A. above shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in A.1.above, or a Level II trauma center as required for the adjustment described in A.3 or A.4.of this Chapter. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased. This limitation does not apply to hospitals qualifying under section A.2.

2. 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 Sections A, B, C, or E of this Chapter 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.

H. Critical Hospital Adjustment Payment Definitions

1. "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001and adjudicated through June 30, 2002

2. "CHAP base period" means State Fiscal Year 1994, for CHAP payments calculated for the July 1, 1995, CHAP rate period, State Fiscal Year 1995 for CHAP payments calculated for the July 1, 1996, CHAP rate period, etc.

3. "CHAP rate period" means, beginning July 1, 1995, the 12- month period beginning on July 1 of the year and ending June 30 of the following year.

4. "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1,1999, plus the Medicaid obstetrical inpatient utilization rate, as of July 1, 1999, both of which are defined in Chapter VI.C.8.

01/11 5. "Coordinated Care Participating Hospital" means 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 that is one of the following:

a. Has entered into a contract to provide hospital services to enrollees of the care coordination program.

b. Has not been offered a contract by a care coordination plan that pays no less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that the Department pays directly.

c. Is not licensed to serve the population mandated to enroll in the care coordination program

65. "Medicaid general care admission" means hospital inpatient admissions, which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.

76. "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an occurrence code of 63 when applicable and an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.

87. "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (H)(5) above.

98. "Medicaid obstetrical care admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with a Diagnosis Related Group (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.

04/05

109."Medicaid trauma admission" means those claims billed as admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31 , 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the

claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18 excluding admissions for normal newborns.

11~~10~~."Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all level II urban trauma centers.

12~~11~~."RCHAP General Care Admission" means Medicaid General Care Admissions, as defined in subsection H.4 above, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.

13~~12~~."RCHAP Obstetrical Care Admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection H. 7 above, with a Diagnosis Related Group (DRG) of 370 through 375, occurring in the CHAP base period.

14~~13~~. "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

15~~14~~."Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

16~~15~~."Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

07/08

r. The hospital meets all of the following criteria in the safety net base year:

i. Does not already qualify under subsections (a)(1) through (a)(17) 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.

01/11

u. 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(t) of this Section.

ii. Is a general acute care hospital.

iii. Is designated a perinatal Level II center by the Illinois Department of Public Health.

iv. Provided greater than 1,000 rehabilitation days in the safety net hospital base year.

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) 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.

02/08

xi. A qualifying hospital that provided greater than 35,000 days in the safety net hospital base year—$43.25.

xii. A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory", with an average length of stay less than 4 days—$48.00.

07/08

b. For a hospital qualifying under Section (1)(b) of these rules, the rate shall be $123.00.

c. For a hospital qualifying under Section (1)(c) of these rules, the rate is the sum of the amounts for each of the following for which it qualifies:

i. A qualifying hospital—$40.

ii. If it has an average length of stay less than 4.00 days and:

A. More than 150 licensed beds —$20.

B. Fewer than 150 licensed beds—$40.

iii. The eligible hospital with the lowest average length of stay—$15.

iv. It has a CMIUR greater than 65 per centum—$35.

v. It has fewer than 25 total admissions in the safety net hospital adjustment base period—$160.

07/08

d. For a hospital qualifying under subsection (1)(d) the rate shall be $110.

e. For a hospital qualifying under subsection (1)(e), the rate is the sum of the amounts for each of the following for which it qualifies divided by the hospital's total days:

i The hospital that has the highest number of obstetrical care admissions—$30,840.

ii. The greater of:

A. The product of $115 multiplied by the number of obstetrical care admissions.

B. The product of $11.50 multiplied by the number of general care admissions.

07/08

f. For a hospital qualifying under subsection (1)(f), the rate is $56.00.

01/11

g. For a hospital qualifying under subsection (1)(g) of this Section, the rate is $315.50 through June 30, 2012. For dates of service on or after July 1, 2012, the rate is $210.50.

01/11

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

01/11

i. For a hospital qualifying under subsection (1)(i) of this Section, the rate is $133.00 ~~through June 30, 2012~~. For dates of service on or after January 1, 2011 through June 30, 2012, this rate shall be increased by $72.00 to $205.00. For dates of service on or after July 1, 2012, the rate is $85.50.

01/11 j. For a hospital qualifying under subsection (1)(j) of this Section, the rate is $13.75. For dates of service on or after January 1, 2011 through June 30, 2012, this rate shall be increased by $25.00 to $38.75.

12/09 k. For a hospital qualifying under subsection (1)(k) of this Section, the rate is $421.00 through June 30, 2012. For dates of service on or after July 1, 2012, the rate is $39.50.

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

04/09 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.

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.

12/09 r. For a hospital qualifying under subsection (1)(s) of this Section, the rate is $56.00 through June 30, 2012. For dates of service on or after July 1, 2012, the rate is $16.00.

01/11 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 $229.00. For dates of service on or after January 1, 2011 through June 30, 2012, this rate shall be increased by $113.00 to $342.00. For dates of service on or after July 1, 2012, the rate is $145.00.

01/11 t. For a hospital qualifying under subsection (1) (u) of this Section, the rate is $71.00 through June 30, 2012. For dates of service on or after July 1, 2012, the rate is $0.00.

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.

01/11 c. For the rate period occurring January 1,2011, to June 30, 2011, payments will equal the hospital's rate multiplied by two multiplied by Total days, less the amount the hospital received for the quarters ending September 30, 2010 and December 31, 2010.

01/11 k) "Safety net hospital base year" means the 12-month period beginning on July 1, 1999, and ending on June 30, 2000.

~~7/02~~01/11 ~~k)~~l) Safety Net Hospital Adjustment Period means, beginning July 1 2002 the 12- month period beginning on July 1 of the year ending June 30 of the following year.

~~l)~~m) "Total admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for individuals eligible for Medicare under title XVIII of that act (Medicaid/Medicare crossover admissions), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.

~~m)~~n) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under title XVIII of that act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.

01/11 6. Payment Limitations. In order to be eligible for any new payment or rate increase under Section K, that would otherwise become effective for dates of service on or after January 1, 2011, a hospital 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* must be 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.L.