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**

07/02 4. PRESCRIBED DRUGS:

02/12 a. REIMBURSEMENT. ~~Effective July 1, 2002, e~~Except for Critical Clinic Providers described in Chapter 1, subsection (1)(e), ~~and the Senior Care Waiver Program,~~ pharmacies will be reimbursed for prescribed drugs at the lower of:

i. The~~ir~~ pharmacy's usual and customary charge to the general public.

ii. The applicable methodology from among the following plus the applicable dispensing fee:

~~A. Single and multiple source legend products for which the average wholesale price is actual market average wholesale price.~~	~~Actual market wholesale cost.~~
~~B~~A. ~~Other s~~Single source legend drugs ~~products~~.	Effective February 1, 2012, the lower of: ~~Standard package size average w~~Wholesale ~~price~~ acquisition cost of national drug code on claim, ~~less~~ plus 1~~2~~%. The State upper limit.
~~C~~B. ~~Other m~~Multiple source legend drugs ~~products not approved for generic interchange by the Illinois Department of Health~~.	Effective June 1, 2012, t~~T~~he lower of: ~~Standard package size average wholesale price~~ Wholesale acquisition cost of national drug code on claim, ~~less 25%~~ plus 1%. The federal upper limit. The State upper limit.
~~D. Other multiple source legend products approved for generic interchange by the Illinois Department of Health.~~	~~The lower of:~~ ~~Standard package size average wholesale price of national drug code on claim, less 25%.~~ ~~The State upper limit.~~ ~~The federal upper limit.~~

02/12 b. For multiple source legend and OTC drugs, the State upper limit reimbursement will apply to certain drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Agency. Multiple source drugs are subject to a State upper limit where the Food and Drug Administration (FDA) has rated at least two drug products pharmaceutically and therapeutically equivalent, including at least one non-innovator product. Single-source legend and OTC drugs will be subject to a State upper limit, on a case-by-case basis, where acquisition cost data demonstrates that acquisition cost is consistently and significantly lower than WAC plus 1 percent for a particular drug.

02/12 ~~b~~c. DISPENSING FEE: ~~Except for the Senior Care Waiver Program,~~Effective February 11, 2012, the dispensing fee shall be $3.40 for ~~brand name~~ single source drugs and ~~$4.60~~ $6.35 for ~~generic~~ multiple source drugs.

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02/12 ~~e~~d. CRITICAL CLINIC PROVIDERS. Reimbursement for prescribed drugs dispensed by Critical Clinic Providers shall be at the rate described in Chapter 1, subsection (1)(e)(ii) for that class of providers.

~~07/03~~02/12 ~~d~~e. PRICING. Drug prices are updated no less frequently than monthly utilizing data procured from a national drug database source. ~~First Data Bank, Inc., of San Bruno, California.~~

10/11 5. OVER-THE-COUNTER DRUGS: Effective February 1, 2012, pharmacies will be reimbursed for over-the-counter drugs at the lower of:

The pharmacy's ~~Lesser of the~~ usual and customary charge to the general public.
~~or t~~The ~~W~~wholesale acquistion cost plus ~~up to 50~~ 25 percent.
The State upper limit.

04-09 6. OTHER LABORATORY AND X-RAY SERVICES: Lesser of the usual and customary charge to the general public or statewide maximums established by the Department not to exceed the upper limits specified in federal regulations. Reimbursement is based upon the applicable modifier billed by the provider, and will be either for the technical component, the professional component or a global amount.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Other Laboratory and X-ray services. The agency's fee schedule rate was set as of February 1, 2010, and is effective for services provided on or after that date. All rates are published on the Department's website in Practitioner Fee Schedule located at www.hfs.illinois.gov/feeschedule/.

04-09 7. PHYSICIAN's SERVICES: Reimbursement for physician services are at the physician's usual and customary charges, not to exceed the maximum established by the Department. Initially, maximum fee-for-service rates were established in 1978 when the Department reviewed the average charges for each of the allowable services. The Department agreed to set the statewide maximum amount at 70 percent of the average charge by physician. Annually the Department analyzes cost information and procedure code utilization of physician bills presented for Medicaid reimbursement of services rendered. The rate maximums are periodically adjusted based upon the above factors.

04-09 Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician services. The agency's fee schedule rate was set as of February 1, 2010, and is effective for services provided on or after that date. All rates are published on the Department's website in the Practitioner Fee Schedule located at www.hfs.illinois.gov/feeschedule/.

Providers, including practitioners working under the supervision of the physician and billing under the physician's name and provider number, statewide who meet the participation requirements for the Maternal and Child Health Program receive enhanced reimbursement rates for services provided to pregnant women and children through age 20 who are participants in the MCH Program. The enhanced rates, which are detailed on the practitioner fee schedule and paid in combination with the maximum fee-for-service rates, include:

- payment for performing a prenatal risk assessment ($15);
- payment for performing risk assessments on children ($15);
- increased reimbursement for deliveries ($400 additional);
- a $10 increase in the EPSDT screening rate; and
- an 8 percent increase in the reimbursement rate for office visits for children.

04-09 The rate for all physician services provided on or after July 1, 2002, shall be the rate in effect June 30, 2002, less 2.6 percent.

04-09 Physicians employed by government-operated entities other than hospitals, long term care facilities, and cost-reporting clinics.

For services provided by salaried physicians employed by a government-operated entity that is not a hospital, long term care facility, or cost-reporting clinic, the State or local government agency operating that entity may elect to enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to physician services provided by the entity and the funding thereof, including

04/09 supplemental payments to universities for certain physician services. This methodology also applies to podiatric services in item 10 and chiropractic services in item 11.

a. Effective April 1, 2009, supplemental payments are available for services, eligible under Title XIX of the *Social Security Act*, that are provided by physicians who are employed by either the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Chicago, the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Rockford, the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Peoria, or the SIU Physicians and Surgeons, Inc at the Southern Illinois University School of Medicine at Springfield.

   i. Physician services eligible for supplemental payments shall include:

      A. services provided by an Advanced Practice Nurse (APN) or Physician's Assistant (PA) when billed under the collaborating physician's name and provider ID, and

      B. services provided by interns and residents when billed under the teaching physician's name and provider ID.

   ii. Physician services eligible for supplemental payments shall not include services provided by contracting physicians nor any other non physician not specified in the state plan.

   iii. Such supplemental payments will be made on a quarterly basis as described below.

b. Definitions

   i. Average Commercial Fee Schedule means, the average commercial fee schedule paid to the university for practitioner services, including patient share amounts, for each CPT code. This average shall be based on the participating university's payments from the five largest private insurance carriers for the CPT services.