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State/Territory Name: IL

State Plan Amendment (SPA) #: 15-019

This file contains the following documents in the order listed:

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

FEB 14 2017

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

RE: Illinois State Plan Amendment (SPA) 15-019

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-019. Effective January 1, 2016, this SPA implements revised inpatient payment methodologies for large public hospitals.

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 regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 15-019 is approved effective January 1, 2016. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Fredrick Sebree, of my staff, at (217) 492-4122 or by e-mail at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosure

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 15-0019	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: January 1, 2016	

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:	7. FEDERAL BUDGET IMPACT
Section 1902 of the *Social Security Act*	a. FFY 2016 N/A b. FFY 2017 N/A
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Page 10.1, ~~155 and 156~~ 30.1, 30.5 ~~Attachment 4.19-B, Page 13.1 and 65~~ 155A 155A	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A, Page 10.1, ~~155 and 156~~ 30.1, 30.5, 155A/155A ~~Attachment 4.19-B, Page 13.1 and 65~~

10. SUBJECT OF AMENDMENT:
Implements revised inpatient and outpatient payment methodologies for large public hospitals

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]	16. RETURN TO:
13. TYPED NAME: Felicia F. Norwood	Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Mary Doran 201 South Grand Avenue East Springfield, IL 62763-0001
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: FEB 14 2017
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2016	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

FORM CMS-179 (07/92) *Instructions on Back*

B. Excluded from DRG PPS reimbursements are:

1. Psychiatric services provided by:
   a. A psychiatric hospital, as described in Chapter VIII.
   b. A distinct part of psychiatric unit, as described in Chapter VIII.
2. Physical rehabilitation services provided by:
   a. A rehabilitation hospital, as described in Chapter VIII.
   b. A distinct part rehabilitation unit, as described in Chapter VIII.
3. Services provided by a long term acute care hospital, as described in Chapter VIII that are not psychiatric services or services described in subsections 1.and 2. of this Section.
4. Inpatient services reimbursed pursuant to negotiation as described in Section A.5 of Chapter VIII.

01/16

5. Services provided by a large public hospital, as ~~described in Chapter XXX~~ defined in Chapter VII, C.
6. Hospital residing long term care services, as described in Chapter XI.
7. Sub-acute alcoholism and substance abuse treatment services, as defined in Section P. of Chapter VIII.

8) Inpatient services provided by Children's Specialty Hospitals as described in Chapter VIII.

9) Non-transplant inpatient services provided by non-cost reporting hospitals, which will be reimbursed at a rate equal to the higher of $672.24 per day or the provider's per diem rate in effect on June 30, 2014.

IV. Methodology for Determining DRG Prospective Payment Rates Effective July 1, 2014

A-1. Inpatient hospital services that are not excluded from the DRG PPS pursuant to Chapter II. shall be reimbursed as determined in this Section.

B-1. Total DRG PPS payment. Under the DRG PPS, services to inpatient who are:

1. Discharges shall be paid pursuant to subsection (c).
2. Transfers shall be paid pursuant to subsection (g)
3. The total payment for an inpatient stay will equal the sum of the payment determined in subsection (c) or (g), as applicable, and any applicable adjustments to payment specified in this Attachment.

C-1. DRG PPS payment for discharges. The reimbursement to hospitals for inpatient services based on discharges shall be the product, rounded to the nearest hundredth, of the following:

1. The greater of:
   a. 1.0000, or
   b. highest policy adjustment factor, as defined in subsection (f), for which the inpatient stay qualifies.
2. The sum of the DRG base payment, as defined in subsection (d), and any applicable outlier adjustment, as determined in Chapter V for which the claim qualifies.

01/16 D-1. For non-Large Public Hospitals, the ~~The~~ DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:

1. The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the DRG grouper.
2. The DRG base rate, equal to the sum of:
   A. The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare IPPS wage index, the statewide standardized amount and the GME factor.
   B. The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the statewide standardized amount and the GME factor.

01/16 I-1. For Large Public Hospitals as defined in Chapter VII, A and B, the DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:

1. The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the grouper.

2. The DRG base rate determined such that simulated base period (as defined in Chapter XXX) DRG payments are equal to adjusted base period costs, as determined in subsection D.4 of Chapter XXX.

01/16 ~~I~~J-1. Definitions.

"Allocated static payments" means the State plan approved adjustment payments in Chapter XV effective during State fiscal year 2011, excluding those payments that continue after July 1, 2014 , allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Discharge" means a hospital inpatient that (i) has been formally released from the hospital, except when the patient is a transfer or (ii) died in the hospital.

"DRG" means diagnosis related group, as defined in the DRG grouper, based the principal diagnosis, surgical procedure used, age of patient, etc.

"DRG average length of stay" means, for each DRG and SOI combination, the national arithmetic mean length of stay for that combination rounded to the nearest tenth, as published by 3M Health Information Systems for the DRG grouper.

"DRG grouper" means the most recently released version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, DRG grouper means the version 30 of the APR-DRG software.

"DRG PPS" means the DRG prospective payment system as described in this Attachment.

"DRG weighting factor" means, for each DRG and SOI combination shall equal the product, rounded to the nearest ten-thousandth, of the national weighting factor for that combination, as published by 3M Health Information Systems for the DRG grouper, and the Illinois experience adjustment.

"GME factor" means the Graduate Medical Education factor applied to major teaching hospitals as defined in Chapter XVIII, determined such that simulated payments under the new inpatient system with GME factor adjustments are $3 million greater than simulated payments under the new inpatient system without GME factor adjustments, using inpatient base period paid claims data.

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 **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 years prior to the calendar year during which the payment period begins.

"PAYMENT PERIOD" means the State fiscal year.

01/16 B. Notwithstanding any other provision of this Attachment, reimbursement to LARGE PUBLIC HOSPITALS shall be at allowable cost, as determined in section D and E 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.

03/14 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.

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.

01/16 E. Large Public Hospitals reimbursed under this chapter shall be reimbursed at allowable cost on a DRG basis for acute care discharges on or after January 1, 2016 in accordance with Chapter IV of this Attachment.