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State/Territory Name: IL

State Plan Amendment (SPA) #: 19-0005

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

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

Financial Management Group

August, 27, 2019

Theresa Eagleson, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0001

RE: State Plan Amendment (SPA) 19-0005

Dear Ms. Eagleson:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number 19-0005. This amendment proposes changes to the "DRG and EAPG Grouper" definitions.

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 implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July, 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

cc:
Fredrick Sebree
Tom Caughey

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: **19-0005**
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: **July 1, 2019**

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 2019 $0**
b.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 30.2
Attachment 4.19-A, Page 30.3
Attachment 4.19-A, Page 30.5
Attachment 4.19-B, Page 21.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable):*
Attachment 4.19-A, Page 30.2
Attachment 4.19-A, Page 30.3
Attachment 4.19-A, Page 30.5
Attachment 4.19-B, Page 21.1

10. SUBJECT OF AMENDMENT:
Updates to the DRG and EAPG Grouper

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: **Theresa Eagleson**

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

15. DATE SUBMITTED

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: AUG 27 2019

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

Instructions on Back

E-1. Medicare IPPS wage index. Medicare IPPS wage index is determined based on:

1. For Medicare IPPS hospitals that are in-state or are out-of-state Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system hospital post-re-class wage index effective October 1, 2012.
2. For in-state non-Medicare IPPS hospitals and out-of-state non-Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective October 1, 2012.

F-1. Policy adjustments. Claims for inpatient stays that meet certain criteria may qualify for further adjustments to payment.

1. Transplantation services.
   a. Policy adjustment factor: 2.11.
   b. Qualifying criteria.
      i. The hospital meets all requirements to perform transplantation services and is certified as a transplant center.
      ii. The claim has been grouped to one of the following DRGs:

	001	Liver transplant.
	002	Heart and/or lung transplant.
07/19	~~003~~	~~Bone marrow transplant.~~
	006	Pancreas transplant.
07/19	007	Allogeneic bone marrow transplant.
07/19	008	Autologous bone marrow transplant.
	440	Kidney transplant.

2. Trauma services.

   a. Policy adjustment factor:

      i) 2.9100, if the hospital is a level I trauma center.

      ii) 2.7600, if the hospital is a level II trauma center.

   b. Criteria:

      i. Hospital is recognized by the Department of Public Health as a level I or II trauma center on the date of admission.

      ii.. The claim has been grouped to one of the following DRGs:

07/19	010	Head trauma with deep coma
	020	Craniotomy for trauma
	055	Head trauma, with coma lasting more than on one hour or no coma.
	056	Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.
	057	Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.
	135	Major chest and respiratory trauma.
	308	Hip and femur procedures for trauma, except joint replacement.
	384	Contusion, open wound and other trauma to skin and subcutaneous tissue.
07/18	841	Extensive three degree burns with skin graft, as of July 1, 2018 through June 30, 2020.
07/18	842	Full thickness burns with graft, as of July 1, 2018 through June 30, 2020.
07/18	843	Extensive burns without skin graft, as of July 1, 2018 through June 30, 2020.
07/18	844	Partial thickness burns with or without graft, as of July 1, 2018 through June 30, 2020.
	910	Craniotomy for multiple significant trauma.
	911	Extensive abdominal/thoracic procedures for multiples significant trauma.
	912	Musculoskeletal and other procedures for multiple significant trauma.
	930	Multiple significant trauma, without operating room procedure.

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 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 thereafter the beginning January 1, 2019, DRG grouper means the version 30 of the APR-DRG software.

07/1819 Effective July 1, 2018 through June 30, ~~2020~~2019, "DRG grouper" means the DRG grouper version 33 of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems.

07/19 Effective July 1, 2019, "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, as determined by the Department.

"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.

1.1. Reimbursement for Hospital Outpatient and Provider-Based Clinic Services Effective for Services on or after July 1, 2014.

j. Definitions

"Aggregate ancillary cost-to-charge ratio" means the ratio of each hospital's total ancillary costs and charges reported in the Medicare cost report, excluding special purpose cost centers and the ambulance cost center, for the cost reporting period matching the outpatient base period claims data. Aggregate ancillary cost-to-charge ratios applied to SFY 2011 outpatient base period claims data will be based on fiscal year ending 2011 Medicare cost report data.

"Consolidation factor" means a factor of 0 percent applicable for services designated with a Same Procedure Consolidation Flag or Clinical Procedure Consolidation Flag by the EAPG grouper under default EAPG settings.

"Default EAPG settings" means the default EAPG grouper options in 3M's Core Grouping Software for each EAPG grouper version.

"EAPG" means Enhanced Ambulatory Patient Groups, as defined in the EAPG grouper, which is a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Services provided in each EAPG have similar clinical characteristics and similar resource use and cost.

07/~~18~~19 "EAPG grouper" means the most recently released version of the Enhanced Ambulatory Patient Group (EAPG) software, distributed by 3M Health Information Systems., available to the Department as of January 1 of the calendar year during with the discharge occurred; except, for the calendar year beginning January 1, 2014, EAPG grouper means the version 3.7 of the EAPG software. Effective July 1, 2018 through June 30, ~~2020~~2019, "EAPG grouper" means the EAPG grouper version 3.11 of the Enhanced Ambulatory Patient Group (EAPG) software, distributed by 3M Health Information Systems.

07/19 Effective July 1, 2019, "EAPG Grouper" means, the most recently released version of the Enhanced Ambulatory Patient Grouping (EAPG) software, distributed by 3M Health Information Systems, as determined by the Department.

"EAPG PPS" means the EAPG prospective payment system as described in this Section.

"EAPG weighting factor" means, for each EAPG, the product, rounded to the nearest ten-thousandth, of (i) the national weighting factor, as published by 3M Health Information Systems for the EAPG grouper, and (ii) the Illinois experience adjustment.

07/18 "Estimated cost of outpatient base period claims data" means the product of (i) outpatient base period paid claims data total covered charges, (ii) the critical access hospital's aggregate ancillary cost-to-charge ratio, and (iii) a rate year cost inflation factor. Effective July 1, 2018 through June 30, 2020, "estimated cost of outpatient base period claims data" means the product of (i) outpatient base period claims data total covered charges, (ii) the critical access hospital's detailed ancillary cost-to-charge ratios, and (iii) a rate year cost inflation factor.

"Freestanding Emergency Center (FEC)" means a facility 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.

"High outpatient volume" means the number paid outpatient claims described in Section (b)(i) provided during the high-volume outpatient base period paid claims data.