

Table of Contents

State/Territory Name: Illinois

State Plan Amendment (SPA) #: 20-0005

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

Financial Management Group

July 1, 2020

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

RE: Illinois State Plan Amendment (SPA) 20-0005

Dear Ms. Eagleson:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid State plan submitted under transmittal number 20-0005 titled "Changes to hospital inpatient and outpatient reimbursement".

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, 2020. 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,



Karen Shields
Acting Director

cc:
Fredrick Sebree
Deborah Benson

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 20-0005	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, 2020

5. TYPE OF PLAN MATERIAL (*Check One*)


NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

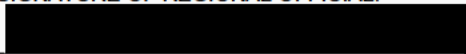
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 of the Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY 2020 \$ 84,375,000.00 IP: \$28,000,000 OP: \$56,375,000 b. FFY 2021 \$337,500,000.00 IP: \$112,000,000 OP: \$225,500,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Refer to Box 23	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Refer to Box 23

10. SUBJECT OF AMENDMENT:
Changes to hospital inpatient and outpatient reimbursement

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
 OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: 	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
13. TYPED NAME: Theresa Eagleson	
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED April 10, 2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 4/10/2020	18. DATE APPROVED: 7/1/20
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2020	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME Karen Shields	22. TITLE: Acting Director, FMG

23. REMARKS:
Attachment 4.19-A: 10.1, 30.1, 30.3, 30.3A, 30.4–30.7, 59.1, 69.1, 74C, 74E, 135, 136, 155B, 172 and 176
Attachment 4.19-A New Page: 176A
Attachment 4.19-B: 11.1, 13.1, 14.1, 17.1, 20.1, 21.1, 23.1, 25.1A, 57 and 65
Attachment 4.19-B New Page: 65A

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

State: **Illinois**

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

- 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 maintained by the Illinois Department of Human Services, as defined in Chapter VII.
 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.
 - 07/15 10. Long Acting Reversible Contraception.

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**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

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 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.
- 07/20 D-2. Effective July 1, 2018, for out-of-state, cost reporting hospitals, 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 out-of-state standardized amount and the GME factor.
 - B. The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the out-of-state standardized amount and the GME factor.

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

State: **Illinois**

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MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

- 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 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.
07/20	841	Extensive three degree burns with skin graft, as of July 1, 2018.
07/20	842	Full thickness burns with graft, as of July 1, 2018.
07/20	843	Extensive burns without skin graft, as of July 1, 2018.
07/20	844	Partial thickness burns with or without graft, as of July 1, 2018.
	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.

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

State: **Illinois**

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

3. Perinatal services.
 - a. Policy adjustment factor:
 - i. 1.3500, if the DRG to which the claim is grouped has an SOI of 1.
 - ii. 1.4300, if the DRG to which the claim is group has an SOI of 2.
 - iii. 1.4100, if the DRG to which the claim is grouped has an SOI of 3.
 - iv. 1.5400, if the DRG to which the claim is grouped has an SOI of 4.

07/20

- b. Criteria:
 - i. Hospital was recognized by the Department of Public Health as a level III perinatal center on the date of admission. Effective July 1, 2018 , hospital was recognized by the Department of Public Health as a level II, II+ or III perinatal center on the date of admission.
 - ii. The claim has been grouped to one of the following MDCs:
 - 14 Pregnancy, childbirth and puerperium
 - 15 Newborn and other neonates.

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MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

4. Safety Net
 - a. Policy adjustment factor: \$57.50 per general acute care day.
 - b. Qualifying criteria: Hospital is a safety-net hospital, excluding pediatric hospitals as defined in Chapter II.C.3. A safety net hospital is defined as a hospital:
 - i. Licensed by the Department of Public Health as a general acute care or pediatric hospital.
 - ii. Reserved.
 - iii. Meets one of the following:
 - A. has a MIUR of at least 40% and a charity percent of at least 4%; or
 - B. has a MIUR of at least 50%.
 - iv. Is a hospital that would have qualified for the rate year beginning October 1, 2011, shall be a Safety-Net Hospital.
 - c. Effective for dates of service on or after July 1, 2014.

07/20

5. Crossover Adjustment Factor effective July 1, 2018
DRG standardized amounts, as defined in subsection J-1, shall be reduced by a Crossover Adjustment factor such that the absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment factor to simulated DRG payments, including Policy Adjustments, using general acute hospital inpatient base period claims data, is equal to the difference of:
 - a. total simulated DRG payments using general acute hospital inpatient crossover claims data, and
 - b. general acute hospital inpatient crossover claims data total reported Medicaid net liability.

G-1. DRG PPS payment for transfers. The reimbursement to hospitals for inpatient services provided to transfers shall be lesser or:

1. The amount that would have been paid pursuant to subsection C-1 had the inpatient been a discharge.
2. The product, rounded to the nearest hundredth, of the following:
 - a. The quotient resulting from dividing the amount that would have been paid pursuant to subsection C-1, had the inpatient been a discharge by the DRG average length of stay for the DRG to which the inpatient claim has been assigned.
 - b. The length of stay plus the constant 1.0.

H-1. Updates to DRG PPS reimbursement. The Department may annually review the components as listed in subsection (c) and make adjustments as needed. Grouper shall be updated at least triennially and no more frequently than annually.

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

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**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

- 01/16 I-1. For Large Public Hospitals as defined in Chapter VII, excluding those maintained by the Illinois Department of Human Services, 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.
- 07/20 “DRG grouper” means the version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software distributed by 3M Health Information Systems being used by the Department for pricing fee-for-service hospital inpatient acute care claims.
- “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 HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

“Illinois experience adjustment” means for the calendar year beginning January 1, 2014, a quotient, computed by dividing the constant 1.0000 by the arithmetic mean 3M APR-DRG national weighting factors of claims for inpatient stays subject to reimbursement under the DRG PPS using inpatient base period paid claims data, rounded to the nearest ten-thousandth; for subsequent calendar years, means the factor applied to 3M APR-DRG national weighting factors, when updating DRG grouper versions determined such that the arithmetic mean DRG weighting factor under the new DRG grouper version is equal to the arithmetic mean DRG weighting factor under the prior DRG grouper version using inpatient base period claims data.

“Inpatient base period claims data” means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible for DRG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, a more recently available adjudicated 12 months of inpatient paid claims data to be identified by the Department.

“Inpatient stay” means a formal admission into a hospital, pursuant to the order of a licensed practitioner permitted by the state in which the hospital is located to admit patients to a hospital that requires at least one overnight stay.

“Length of stay” means the number of days the patient was an inpatient in the hospital; with the day of the patient became a discharge or transfer not counting toward the length of stay.

“Medical assistance” means one of the programs administered by the Department that provides health care coverage to Illinois residents.

“Medicare CBSA” means the Core-Based Statistical Areas for a hospital’s location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

“Medicare IPPS labor share percentage” means the Medicare inpatient prospective payment system operating standardized amount labor share percentage for the federal fiscal year ending three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the labor share percentage in the Medicare inpatient prospective payment system for the federal fiscal year beginning October 1, 2012, which is 0.6880 for a hospital with a Medicare IPPS wage index greater 1.0 or 0.6200 for all other hospitals.

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“Medicare IPPS non-labor share” means the difference of 1.0 and the Medicare IPPS labor share percentage.

“MDC” means major diagnostic category – group of similar DRGs, such as all those affecting a given organ system of the body.

“SOI” means one of four subclasses of each DRG, as published by 3M Health Information Systems for the DRG grouper that relate to severity of illness (the extent of physiologic de-compensation or organ system loss of function experience by the patient) and risk of (the likelihood of) dying.

“Statewide standardized amount” means the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS payments, without SMART Act reductions or GME factor adjustments, using general acute hospital inpatient based period paid claims data, are \$355 more million less than the sum of inpatient based period paid claims data reported payments and allocated inpatient static payments.

07/20 Effective July 1, 2018, “statewide standardized amount” means (1) all Illinois hospitals, and (2) out-of-state hospitals that are designated a level I pediatric trauma center or a level I trauma center by the Illinois Department of Public Health as of December 1, 2017, the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS allowed amounts, less the rate reductions defined in Chapter XL of this Attachment, results in approximately a \$238.5 million increase inclusive of policy adjusters effective July 1, 2018 as defined in subsections (2) and (3) of this Section, compared to the sum of the inpatient based period claims data allowed amounts.

“Transfer” means a hospital inpatient that has been placed in the care of another hospital except that a transfer does not include an inpatient claim that has been assigned to DRG 580 (Neonate, transferred, less than five days old, not born here) or 581 (Neonate, transferred, less than five days old, born here).

07/20 Effective July 1, 2018, “out-of-State standardized amount” means for cost-reporting hospitals located outside of Illinois that are not included in the in-state standardized amount, the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS allowed amounts, without SMART Act reductions or GME factor adjustments, using general acute hospital inpatient based period claims data, are equal to the sum of inpatient based period claims data allowed amount.

07/20 Effective July 1, 2018, “allowed amounts” means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for inpatient priced claims via the DRG-PPS, excluding Medicare dual eligible claims, for which the date of discharge is in inpatient base period claims data.

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

State: **Illinois**

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

	020	Craniotomy for trauma.
	055	Head trauma, with coma lasting more than one hour or hemorrhage.
	056	Brain contusion/laceration and complicated skull fracture, coma less than one or no coma
	057	Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.
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07/20	843	Extensive burns without skin graft, as of July 1, 2018 .
07/20	844	Partial thickness burns with or without graft, as of July 1, 2018.
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STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

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- d. Distinct part rehabilitation unit. Payment for inpatient rehabilitation services provided by a distinct part rehabilitation unit, as defined in Chapter VII:
 - i. For which the Department had no inpatient base period paid claims data, shall be the product of the following:
 - A) The arithmetic mean rate for rehabilitation distinct part units.
 - B) The length of stay, as defined in subsection A.1.c.i.B. above.
 - ii. For which the Department had inpatient base period paid claims data, shall be product of the following:
 - A) The lesser of:
 - 1) The greater of:
 - a) The distinct part rehabilitation unit rate, as determined in subsection A.2.e. of this Chapter, and
 - b) 80% of the-arithmetic mean rate for rehabilitation distinct part units
 - 2) The arithmetic mean rehabilitation rate for rehabilitation distinct part units plus the value of one standard deviation of the rehabilitation rate for rehabilitation distinct part units.
- e. The rehabilitation rate is calculated as the sum of:
 - i. The rehabilitation rate as in effect on July 1, 2011.
 - ii. The quotient, rounded to the nearest hundredth, of the rehabilitation provider's allocated static payments divided by the rehabilitation provider's inpatient covered days in the inpatient base period paid claims data.
 - iii Effective July 1, 2018, - plus \$96.00.

07/20

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

State: **Illinois**

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

4. Reimbursement Methodologies for Children's Specialty Hospitals

- a. Inpatient general acute care services provided by a Children's Specialty Hospital located in Illinois as defined in Chapter II.C.3. and with fewer than 50 total inpatient beds and excluded from the DRG PPS shall per day of covered inpatient care be reimbursed as follows:
 - i. For a hospital that would not have met the definition of a children's specialty hospital as of July 1, 2013, \$1,400.00 per day.
 - ii. For a hospital that would have met the definition of a children's specialty hospital as of July 1, 2013, a rate equal to the per diem base rate in place on July 1, 2013, multiplied by a factor of 1.37.
 - iii. The total payment for inpatient stay will equal the sum of:
 - A) The payment determined in this Section; and
 - B) Any applicable adjustments to payment specified in Chapters VI, VIII, XV and XL.

07/20

- b. Effective July 1, 2018, rates in subsection 4.a. above are increased by 10.5 percent.

07/20

- c. Reserved.

- d. For cost reporting hospitals located outside of Illinois that meet the definition of a Children's specialty hospitals as defined in Chapter VII as of June 30, 2014, for inpatient general acute care and rehabilitation services, the hospital shall have a per diem amount equal to the rate in place with the Department as of June 30, 2014. The total payment for inpatient stay will equal the sum of the payment determined in this Subsection and any applicable adjustments to payments specified in Chapters VI, VIII, XV and XL.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Illinois

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

e. 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.

“Long term acute care hospital” is a facility licensed by the state within which it is located as an acute care hospital and certified by Medicare as a long term care hospital.

“Inpatient base period paid claims data” means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims.

f. Long term acute care supplemental per diem rates.

- i. The long term acute care supplemental per diem rates, as authorized under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], shall be the amount in effect as of October 1, 2010.
- ii. No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.

07/20

- g. Effective July 1, 2018, rates in this subsection are increased by 10.5 percent.

01/20

- h. Effective January 1, 2020, the base per diem rate for Medicaid services shall be \$60 more than the base rate in effect on June 30, 2019.

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

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**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

07/18 **XVII. Graduate Medical Education (GME) Payment.**

A. Definitions:

- 07/20 1. Medicare cost report ending in 2018, as reported in Medicare cost reports released on October 19, 2019, with data through September 30, 2019.
2. "Hospital's annualized Medicaid Intern Resident Cost" is the product of the following factors:
- 07/20 a. Annualized intern and resident costs obtained from Worksheet B Part I, Column 21 and 22 the sum of lines 30-43, 50-76, 90-93, 96-98, and 105-112
- b. A quotient of:
- i. the numerator of which is the hospital's Medicaid days (Worksheet S3 Part I, Column 7, Lines 2-4, 14, 16-18 and 32); and
- ii. the denominator of which is the hospital's total days (Worksheet S3 Part I, Column 8, Lines 14 and 16-18).
3. "Hospital annualized Medicaid IME payment is the product of the following factors:
- a. Hospital IME payments (Worksheet E Part A, Line 29, Col 1).
- 07/20 b. A quotient of:
- i. the numerator of which is the hospital Medicaid days (Worksheet S3 Part I, Column 7, Lines 2-4, 14, 16-18 and 32); and
- ii. the denominator of which is the hospital Medicare days (Worksheet S3 Part I, Column 6, Lines 2-4, 14 and 16-18).
- 07/20 4. "Statewide average cost per intern and resident" is the quotient of:
- a. The sum of
- i. all qualifying hospitals annualized Medicaid Intern Resident Cost
- ii. all qualifying hospitals annualized Medicaid IME payment
- b. the sum of all qualifying hospitals interns and residents as reported on Worksheet S3, Part 1, Col 9, line 14
- B. Qualifying Criteria: An Illinois hospital, excluding large public hospitals, reporting intern and resident cost on its Medicare cost report ending in 2018 shall be eligible for a graduate medical education payment.

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

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**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

- C. Payment. A qualifying hospital shall receive a payment that is the product of the following factors:
1. the lesser of:
 - a. the sum of the hospital's annualized Medicaid Intern Resident Cost and annualized Medicaid IME payment, or
 - b. the product of:
 - i. the number of interns and residents as reported on Worksheet S3, Part 1, Col 9, line 14, and
 - ii. 120% of the statewide average cost per intern and resident for all eligible hospitals
 2. 22.6 percent.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Illinois

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

- 07/18 G. Graduate Medical Education (GME) Payment.
1. Definitions:
 - a. Medicare cost report ending in 2015, as reported in Medicare cost reports released on October 19, 2016, with data through September 30, 2016.
 - b. “Hospital’s Annualized Medicaid Intern Resident Cost” is the product of the following factors:
 - i. Annualized intern and resident costs obtained from Worksheet B Part I, Column 21 and 22 the sum of lines 30-43, 50-76, 90-93, 96-98, and 105-112
 - ii. A quotient of:
 - 07/20 A. the numerator of which is the hospital’s Medicaid days (Worksheet S3 Part I, Column 7, Lines 2-4, 14, 16-18 and 32), and
 - B. the denominator of which is the hospital’s total days (Worksheet S3 Part I, Column 8, Lines 14 and 16-18).
 - iii. The quotient of:
 - A. the numerator of which is the hospital’s total inpatient charges, and
 - B. the denominator of which is the hospital’s total charges.
 - c. “Hospital annualized Medicaid IME payment is the product of the following factors:
 - i. Hospital IME payments (Worksheet E Part A, Line 29, Col1).
 - ii. A quotient of:
 - 07/20 A. the numerator of which is the hospital Medicaid days (Worksheet S3 Part I, Column 7, Lines 2-4, 14, 16-18 and 32), and
 - B. the denominator of which is the hospital Medicare days (Worksheet S3 Part I, Column 6, Lines 2-4, 14 and 16-18).
 2. Qualifying Criteria: An Illinois large public hospital reporting intern and resident cost on its Medicare cost report ending in 2015 shall be eligible for a graduate medical education payment.
 3. Payment. Effective July 1, 2018, a qualifying hospital shall receive a payment that is the sum of each hospital’s annualized Medicaid Intern Resident Cost and annualized Medicaid IME payment.
 - 07/20 4. Effective July 1, 2020, payment amounts in this section may be calculated annually, or at least every 3 years, using updated Medicare Cost Report Information. Updated Medicare Cost Report Information shall be the most recent Medicare Cost report available as of October of the calendar year preceding the state fiscal year.

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

State: **Illinois**

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

07/20 **XLV. General Provisions effective July 1, 2020.**

Unless otherwise indicated, the following apply to Chapters XLVI through XLVII.

A. Payments.

1. Effective July 1, 2018, payments shall be paid in 12 installments on or before the 7th State business day of the month.
2. The Department may adjust payments made under these Chapters to comply with federal law or regulations regarding disproportionate share, hospital-specific payment limitations on government-owned or government-operated hospitals as described in Chapter VII.g.7.iv.D. of this Attachment.
3. If the state or federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under these Chapters is exceeded, then the payments under these Chapters that exceed the applicable federal upper payment limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

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

State: **Illinois**

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

07/20 XLVI. Alzheimer's Treatment Access Payment effective July 1, 2020.

- A. **Qualifying Criteria.** An Illinois academic medical center or teaching hospital as defined in Section B.6. of Chapter XLV that is identified as the primary hospital affiliate of one of the regional Alzheimer's Disease Assistance Centers as designated by the Alzheimer's Disease Assistance Act and identified in the Illinois Department of Public Health Alzheimer's Disease State Plan dated December 2016.
- B. **Payment.** A qualifying hospital shall receive a payment that is the product of the following factors:
 - 1. The hospital's State fiscal year 2018 inpatient days; and
 - 2. the hospital's Alzheimer's Treatment Rate:
 - a. For qualifying hospitals located in Cook County: \$226.30
 - b. For qualifying hospitals located outside of Cook County: \$116.21
- C. "Inpatient days" means, for a given hospital, the sum of inpatient hospital days provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care, excluding days for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for total days occurring during State fiscal year 2018 as of July 10, 2019.

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

State: **Illinois**

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

XLVII. Hospital Inpatient Adjustment Effective July 1, 2020

- A. Qualifying Criteria. Non-large publicly owned hospitals located in Illinois qualifying for this payment include:
1. General Acute Care Hospitals
 2. Safety Net Hospitals
 3. Long Term Acute Care (LTAC) Hospitals, as defined in Chapter VIII.A.3.c.iii of this Attachment.
 4. Psychiatric Hospitals, as defined in Chapter VII.A of this Attachment.
 5. Rehabilitation Hospitals, as defined in Chapter VII.B of this Attachment.
 6. Critical Access Hospitals, as defined 42 CFR 485 Subpart F.
- B. Payment. Each qualifying hospital shall receive an annual payment equal to the product of:
1. The hospital's calendar year 2019 inpatient days; and
 2. The rate assigned to the group to which the hospital qualifies:
 - a. General Acute Care Hospitals: \$350
 - b. Safety Net Hospitals: \$960
 - c. LTAC Hospitals: \$295
 - d. Psychiatric Hospitals: \$125
 - e. Rehabilitation Hospitals: \$355
 - f. Critical Access Hospitals: \$385
- C. Definitions:
1. "Safety Net Hospital" means a hospital, as defined in Chapter IV.F-1.4 of this Attachment, except that stand-alone children's hospitals that are not specialty children's hospitals will not be included.
 2. "Inpatient days" means, for a given hospital, the sum of inpatient hospital days provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care, excluding days for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for total days occurring during State calendar year 2019 as of May 11, 2020.

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. EAPG PPS reimbursement. Reimbursement under EAPG PPS, described in subsection c., shall be all-inclusive for all services provided by the hospital, without regard to the amount charged by a hospital. Except as provided in subsection b.iii., no separate reimbursement will be made for ancillary services or the services of hospital personnel.
 - i. Outpatient hospital services reimbursed through the EAPG PPS shall include:
 - A. Surgical services.
 - 07/20 B. Diagnostic and therapeutic
 - C. Emergency department services.
 - D. Observation services.
 - E. Psychiatric treatment services.
 - ii. Reserved.
 - 07/20 iii. Exceptions to all-inclusive EAPG PPS rate.
 - A. A hospital may bill separately for professional services of a physician who provided direct patient care.
 - B. For the purpose of subsection iii.A., a physician means:
 - 1. A physician salaried by the hospital. Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists; no separate reimbursement will be allowed for such providers.
 - 2. A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care.
 - 3. A group of physicians with a financial contract to provide emergency department care.

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**

- d. EAPG standardized amount. The standardized amount established by the Department as the basis for EAPG conversion factor differs based on the provider type:
 - i. County-operated large public hospital EAPG standardized amount. For a large public hospital, as defined in Chapter VII. of Attachment 4.19-A, Page 65.1, the EAPG standardized amount is determined in Chapter 33 of this Attachment.
 - ii. University-operated large public hospital EAPG standardized amount. For a large public hospital, as defined in VII. of Attachment 4.19-A, Page 65.1, the EAPG standardized amount is determined in Chapter 33 of this Attachment.
 - iii. Critical access hospital EAPG standardized amount. For critical access hospitals, that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F., the EAPG standardized amounts are determined separately for each critical access hospital such that:
 - A. Simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Chapter 32 of this Attachment, net of tax costs are equal to:
 - B. Estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.
 - 05/19 C. Effective July 1, 2018 through May 9, 2019, simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Chapter 49 of this Attachment, net of tax costs equal to estimated costs as described in subsection d.iii.B. of this Section.
 - 07/20 D. Effective May 10, 2019, simulated EAPG payments using outpatient base period paid claim data results in a 23% increase compared to the sum of the hospital outpatient base period claims allowed amount.
 - iv. Acute EAPG standardized amount.
 - A. Qualifying criteria. General acute hospitals and freestanding emergency centers, excluding providers in subsections.d.i. through d.iii. in this Section, freestanding psychiatric hospitals, psychiatric distinct part units, freestanding rehabilitation hospitals, and rehabilitation distinct part units.
 - B. The acute EAPG standardized amount is based on a single statewide amount determined such that:
 - 1. Simulated EAPG payments, without rate reductions defined in Chapter 46 of this Attachment or policy adjustments defined in subsection f., using general acute hospital outpatient base period paid claims data, results in approximately a \$75 million increase compared to:
 - 2. The sum of general acute hospital base period paid claims data reported payments and allocated outpatient static payments.
 - 07/20 3. Effective July 1, 2018, in-state hospital simulated EAPG payment using general acute hospital outpatient base period claims data, less the rate reductions defined in Chapter 46 of this Attachment and less the increase in payment from d.3.C. above, results in a \$238 million increase inclusive of add-on payments as defined in subsection k. of this Section, compared to the sum of the acute hospital outpatient based period claims allowed amount.

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**

- 07/20
- v. Psychiatric EAPG standardized amount.
 - A. Qualifying criteria. Freestanding psychiatric hospitals and psychiatric distinct part units.
 - B. The psychiatric EAPG standardized amount is based on a single statewide amount, determined such that:
 - 1. Simulated EAPG payments, without policy adjustments defined in subsection f. of this Chapter, using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data, results in payments equal to the amount derived in subsection d.v.B.2. of this Chapter.
 - 2. The sum of freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.
 - 3. Effective July 1, 2018, in-state hospital simulated EAPG payment using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period claims data less the rate reductions defined in Chapter 46 of this Attachment results in a \$3,870,000 increase compared to the sum of psychiatric hospital outpatient based period claims allowed amount.
 - vi. Rehabilitation EAPG standardized amount.
 - A. Qualifying criteria. Freestanding rehabilitation hospitals and rehabilitation distinct part units.
 - B. The rehabilitation EAPG standardized amount is based on a single statewide amount, determined such that:
 - 1. Simulated EAPG payments, without rate-reductions described in Chapter 46 of this Attachment or policy adjustments defined in subsection f. of this Chapter, using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data, results in payments approximately equal to:
 - 2. The sum of freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.
 - 3. Effective July 1, 2018, in-state hospital simulated EAPG payment using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period claims data less the rate reductions defined in Chapter 46 of this Attachment results in a \$57,400 increase compared to the sum of rehabilitation hospital outpatient based period claims allowed amount.
 - vii. Out-of-state non-cost reporting hospital EAPG standardized amount. For non-cost reporting hospitals, the EAPG standardized amount is \$362.32, which is not wage adjusted.

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**

- iii. Crossover Adjustment Factor
 - A. Acute EAPG standardized amounts, as defined in subsection d.iv., shall be reduced by a Crossover Adjustment factor such that:
 - 1. The absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment factor to simulated EAPG payments, including Policy Adjustments, using general acute hospital outpatient base period paid claims data, is equal to:
 - 07/18 2. Effective on or after July 1, 2014 through June 30, 2018, the difference of total simulated EAPG payments using general acute hospital outpatient crossover paid claims data, and general acute hospital outpatient crossover paid claims data total reported Medicaid net liability.
 - 07/20 B. Crossover Adjustment Factor, effective in State fiscal years 2015 and 2016, is 0.98912. Effective July 1, 2018, the Crossover Adjustment Factor is defined in iii.A. above, except that the outpatient base period paid claims data is the outpatient base period claims data.
- iv. If a claim does not qualify for a Policy Adjustment described in subsection f.iii. through f.v. of this Section, the policy adjustment factor is 1.0.
- 07/20 v. Reimbursement for High Outpatient Volume hospital services provided on or after July 1, 2018.
 - A. High Outpatient Volume Hospital is defined as:
 - 1. Illinois hospital for which the high outpatient volume is at least one and one-half standard deviations above the mean regional high outpatient volume;
 - 2. Illinois hospital for which the high outpatient volume is at least one and one-half standard deviations above the mean statewide high outpatient volume;
 - 3. Illinois Safety-Net hospital as defined in subsection F-1.4.b. of Chapter IV of Attachment 4.19-A; or
 - 4. Illinois small public hospital defined as any publicly owned hospital that is not a large public hospital.
 - 5. Illinois hospital which qualified as a high outpatient volume hospital as of July 1, 2014.
 - B. Policy adjustment factor is set:
 - 1. For acute care claims such that total expenditures on claims qualifying for a policy adjustor less the rate reductions defined in Chapter 46 of this Attachment is increased by \$79.2 million more than base period qualifying claims allowed amount.
 - 2. For non-acute care claims to equal the factor in place prior to July 1, 2018, as defined in subsection f.ii.D. of this Chapter.

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**

- 07/20 i. Outpatient Physical Rehabilitation Services effective through June 30, 2020.
- The maximum reimbursement rate:
- i. For outpatient physical rehabilitation services provided by a hospital (paid per visit and limited to one visit per day):
 - a. That is a children’s hospital, as defined in Chapter II.C.3. of Attachment 4.19-A, the rate shall be \$130.00.
 - b. Enrolled with the Department to provide outpatient physical rehabilitation, the rate shall be \$130.00.
 - c. Not enrolled with the Department to provide outpatient physical rehabilitation, the rate shall be \$115.00.
 - ii. For all other physical, occupational and speech therapy services (paid per quarter hour), the rate shall be as published in fee schedule on the Department’s website.

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**

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.

07/20 “Default EAPG settings” means the default EAPG grouper options in 3M’s Core Grouping Software for each EAPG grouper version, except where the Department made adjustments.

“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.

07/20 “EAPG grouper” means the version-of the Enhanced Ambulatory Patient Group (EAPG) software, distributed by 3M Health Information Systems., being used by the Department for pricing hospital outpatient services.

“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.

07/20 “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, “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.

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**

- j. Definitions Continued
- 07/20 Effective July 1, 2018 through June 30, 2020, for in-state “Outpatient base period claims data” means State fiscal year 2015 outpatient Medicaid fee-for-service paid claims data and completed MCO encounter claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in State fiscal years 2019 and 2020. Effective July 1, 2020, “outpatient base period claims data” means:
- State fiscal year 2017, outpatient Medicaid claims data for in-state hospitals that are not large public hospitals
 - State fiscal years 2017 and 2018, outpatient Medicaid claims data for out of state hospitals
- 07/20 “Outpatient crossover paid claims data” means outpatient Medicaid/Medicare dual eligible fee-for-service and managed care paid claims data, excluding renal dialysis claims and therapy claims, with dates of service from the same time period as outpatient base period claims.
- “Packaging factor” means a factor of 0 percent applicable for services designated with a Packaging Flag by the EAPG grouper under default EAPG settings plus EAPG 430 (Class I Chemotherapy Drugs), EAPG 435 (Class I Pharmacotherapy), EAPG 495 (Minor Chemotherapy Drugs), EAPG 496 (Minor Pharmacotherapy), and EAPGs 1001-1020 (Durable Medical Equipment Level 1-20), and non-covered revenue codes defined in the Handbook for Hospital Services.
- “Rate year cost inflation factor” means the cost inflation from the midpoint of the outpatient base period paid claims data to the midpoint of the rate year based on changes in Centers for Medicare and Medicaid Services (CMS) input price index levels. For critical access hospital rates effective SFY 2015, the rate year cost inflation factor will be based on changes in CMS input price index levels from the midpoint of SFY 2011 to SFY 2015.
- “Total covered charges” means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMS 1450), or one of its electronic transaction equivalents,
- “Region” means, for a given hospital, the rate region in which the hospital is located as defined below.
- 07/20 “Allowed amounts” means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for OP base period claims data. If volume in base period data is estimated to differ from rate year volume, then completion factors are applied.
- 07/18 “In-state” means (1) all Illinois hospitals, and (2) out-of-state hospitals that are designated a level I pediatric trauma center or a level I trauma center by the Illinois Department of Public Health as of December 1, 2017.

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**

- 07/20 k. Expensive Drugs and Devices Add-On Payment
- i. Qualifying Criteria: In addition to the statewide standardized amounts, the Department shall make an add-on payment for outpatient expensive devices and drugs beginning July 1, 2018, for in-state hospitals as defined in subsection j. of this Chapter. This add-on payment shall apply to claim lines that:
 - A. Are assigned with one of the following EAPGs: 490, 1001 to 1020, and coded with one of the following revenue codes: 0274 to 0276, 0278; or
 - B. Are assigned with one of the following EAPGs: 430 to 441, 443, 444, 460 to 465, 495, 496, 1090.
 - ii. Payment: The add-on payment shall be calculated as follows:
 - A. The product of the following:
 - 1. The claim line's covered charges.
 - 2. The hospital's total acute cost to charge ratio as defined in subsection iii. of this Section.
 - B. The sum of:
 - 1. The claim line's EAPG payment.
 - 2. \$1,000.
 - C. The product of:
 - 1. The difference between subsections ii.A. and ii.B of this Section.
 - 2. 0.8.

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**

- d. Graduate Medical Education (GME) Payment.
- i. Definitions:
- A. Medicare cost report ending in 2015, as reported in Medicare cost reports released on 10/19/2016 with data through 9/30/2016.
- B. “Hospital’s Annualized Medicaid Intern Resident Cost” is the product of the following factors:
1. Annualized intern and resident costs obtained from Worksheet B Part I, Column 21 and 22 the sum of lines 30-43, 50-76, 90-93,96-98, and 105-112
- 07/20 2. A quotient of:
- a. the numerator of which is the hospital’s Medicaid days (Worksheet S3 Part I, Column 7, Lines 2-4, 14 and 16-18 and 32), and
- b. the denominator of which is the hospital’s total days (Worksheet S3 Part I, Column 8, Lines 14 and 16-18).
3. The quotient of:
- a. the numerator of which is the hospital’s total outpatient charges (Worksheet C, Part 1, Column 7, Line 202), and
- b. the denominator of which is the hospital’s total charges (Worksheet C, Part 1, Column 8, Line 202).
- ii. Qualifying Criteria: An Illinois large public hospital reporting intern and resident cost on its Medicare cost report ending in 2015 shall be eligible for a graduate medical education payment.
- iii. Payment. Effective July 1, 2018, a qualifying hospital shall receive a payment that is the product of the sum of the Hospital’s Annualized Medicaid Intern Resident Cost as calculated in subsection d.i.b. of this Section.
- 07/20 iv. Effective July 1, 2020, payment amounts in this section may be calculated annually, or at least every 3 years, using updated Medicare Cost Report Information. Updated Medicare Cost Report Information shall be the most recent Medicare Cost report available as of October of the calendar year preceding the state 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**

07/20 49. General Provisions effective July 1, 2020.

Unless otherwise indicated, the following apply to Chapter 50.

- a. Payments.
 - i. Effective July 1, 2020, payments shall be paid in 12 installments on or before the 7th State business day of the month.
 - ii. The Department may adjust payments made under these Chapters to comply with federal law or regulations regarding disproportionate share, hospital-specific payment limitations on government-owned or government-operated hospitals as described in Chapter VI.C.7.g.iv.D. of Attachment 4.19-A.
 - iii. If the state or federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under these Chapters is exceeded, then the payments under these Chapters that exceed the applicable federal upper payment limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

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**

50. Hospital Outpatient Adjustment Effective July 1, 2020

- A. Qualifying Criteria. Non-large publicly owned hospitals located in Illinois qualifying for this payment include:
1. General Acute Care Hospitals
 2. Safety Net Hospitals
 3. Psychiatric Hospitals, as defined in Chapter VII.A of this Attachment.
 4. Critical Access Hospitals, as defined 42 CFR 485 Subpart F.
- B. Payment. Each qualifying hospital shall receive an annual payment equal to the product of:
1. The hospital's calendar year 2019 outpatient claims; and
 2. The rate assigned to the group to which the hospital qualifies:
 - a. General Acute Care Hospitals: \$620
 - b. Safety Net Hospitals: \$625
 - c. Psychiatric Hospitals: \$130
 - d. Critical Access Hospitals: \$530
- C. Definitions:
1. "Safety Net Hospital" means a hospital, as defined in Chapter IV.F-1.4 of this Attachment, except that stand-alone children's hospitals that are not specialty children's hospitals will not be included.
 2. "Outpatient claims" means, for a given hospital, the sum of outpatient hospital claims accepted by the Department for outpatient services provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care, excluding days for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover claims), as tabulated from the Department's paid claims data for services occurring during calendar year 2019 as of May 11, 2020.