

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 785-0710
TTY: (800) 526-5812

March 20, 2009

ACTION NOTICE

PLEASE NOTE THE REQUIRED DEADLINES DESCRIBED BELOW

To: Cost Reporting Hospitals: CEO, CFO, and Patient Account Manager

RE: Rate Year 2010 Determination for Disproportionate Share, Medicaid Percentage Adjustment, Critical Hospital Adjustment, and County Trauma Center Adjustment Payments

This notice describes the information required by the Department to determine which hospitals will qualify for Disproportionate Share Hospital Adjustment Payments, Medicaid Percentage Adjustment Payments, Critical Hospital Adjustment Payments, and County Trauma Center Adjustment Payments in accordance with the 89 Illinois Administrative Code Sections, 148.120, 148.122, 148.290(c), and 148.295 in rate year 2010. **Claims Data must be adjudicated by the Department by June 30, 2009. The Illinois Administrative Code provides for no exceptions to that deadline.**

CRITICAL HOSPITAL ADJUSTMENT PAYMENTS (CHAP) and COUNTY TRAUMA CENTER ADJUSTMENT PAYMENTS (TCA)

In order to determine eligibility and payment rates for both Critical Hospital Adjustment Payments and County Trauma Center Adjustments, all data defined in Sections 148.290(c), and 148.295 of the Illinois Administrative Code must be adjudicated by June 30, 2009. This includes trauma admissions, obstetrical days, general care admissions, and certain rehabilitation admissions as defined in the sections cited above. Services provided in state fiscal year 2008 (July 1, 2007 - June 30, 2008) for which claims have been received and adjudicated by June 30, 2009, will be used to determine eligibility for these payments. **Claims that have not been adjudicated by June 30, 2009 cannot be considered by the Department.**

DISPROPORTIONATE SHARE (DSH) and MEDICAID PERCENTAGE ADJUSTMENT (MPA) DETERMINATION

The information required by the Department for the Disproportionate Share and Medicaid Percentage Adjustment determination is outlined below. Items 1 through 4 apply to all Illinois hospitals. Out-of-state cost reporting hospitals need only to submit the information required under items 1 and 4. The information needed to calculate Medicaid utilization levels for out-of-state hospitals will be obtained from the Medicaid agency in that state. **Please note that all required information submitted must be based on your hospital's 2007 cost reporting period statistics.**

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March 20, 2009

To: Chief Executive Officers, Chief Financial Officers, and Patient Account Managers

Attached you will find an Action Notice from the Department reminding hospitals of the information used to calculate Disproportionate Share Hospital Adjustment Payments, Medicaid Percentage Adjustment Payments, Critical Hospital Adjustment Payments, and County Trauma Center Adjustment Payments.

The purpose of the attached notice is to remind hospitals that the Department will make determinations based on data on hand and allow you to update information you feel is incomplete. As described in the attachments, claims must be adjudicated no later than June 30, 2009, and other data must be received or postmarked no later than July 1, 2009. Data used to determine eligibility and calculate rates are not from the current period, but from either your hospital's 2007 cost reporting period (DSH and MPA) or the State's 2008 (July 1, 2007 to June 30, 2008) fiscal year (CHAP and TCA). If you have any questions regarding this notice, please contact the Disproportionate Share Unit at (217) 785-0710.

Sincerely,



Joseph R. Holler, Chief
Bureau of Rate Development and Analysis

Attachments

- 1) Hospitals providing non-emergency obstetrical care to the general public must provide, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetrical services to individuals entitled to Illinois Medicaid. Hospitals not offering non-emergency obstetrical care to the general public must provide a statement to that effect. **Please complete Part I OR Part II of the Disproportionate Share Obstetrical Statement and return it to the Department by July 1, 2009.**
- 2) In making the determination, the Department will utilize final audited cost reports for each hospital's 2007 cost reporting period. In the absence of a final audited cost report, the Department will utilize the hospital's unaudited cost report. Data derived from audited cost reports will be considered final. **If your hospital's cost report is unaudited and you feel relevant data therein are incorrect, a corrected cost report must be received or postmarked by July 1, 2009 (metered dates are not acceptable). In accordance with section 148.120(c)(1), cost report corrections received or postmarked beyond July 1, 2009, cannot be considered.**
- 3) Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report. They are: (1) Medicare/Medicaid crossover days, (2) hospital residing long term care days, (3) Illinois Department of Alcohol and Substance Abuse (DASA) days, (4) Medicaid HMO days, and (5) Out-of-state Title XIX Medicaid utilization levels.
 - a) The Department will utilize the Department's paid claims data for each hospital's 2007 cost reporting period to determine the number of Medicare/Medicaid crossover days, hospital residing long term care days, and DASA days. All claims must be adjudicated by June 30, 2009 to be included in the determination and rate setting process.
 - b) The Department will request a special report from each HMO to determine the number of HMO days for each hospital's 2007 cost reporting period.
 - c) Hospital statements and verification reports from other States will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only days of care provided to out-of-state Medicaid recipients during the hospital's 2007 cost reporting period.
- 4) Hospitals may also qualify for Disproportionate Share status if their low income utilization rate exceeds 25%. To calculate a hospital's low income utilization rate, the hospital must fill out the attached Low Income Utilization Collection Form, and submit an audited certified financial statement for their 2007 cost reporting period.

All information described in Sections 1 through 4 above is necessary to conduct the rate year 2010 Disproportionate Share and Medicaid Percentage Adjustment determination and must be received by, or postmarked to the Department no later than July 1, 2009, at the appropriate address listed below. Information for Sections 1 through 4 above that is postmarked after July 1, 2009, will not be considered for the Disproportionate Share or Medicaid Percentage Adjustment determination.

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

Due to proposed federal guidelines, it is imperative in rate year 2010 that the Department collect data found on the OBRA'93 data collection form from all hospitals. It is mandatory, therefore, that the following data be submitted by **all** hospitals for rate year 2010, regardless of DSH eligibility.

In order to determine if the Department meets federal guidelines set forth in the Omnibus Budget Reconciliation Act of 1993 (OBRA'93), all cost reporting hospitals must complete and send the OBRA'93 Data Collection Form to the Department BY AUGUST 15, 2009 (mail postmarked on or before that date is acceptable; metered dates are not acceptable), with the following information for the hospital's 2007 cost reporting period.

1. The dollar amount of Illinois inpatient, outpatient, and hospital based clinic Medicaid charges.
- 2a. The dollar amount of total inpatient, outpatient, and hospital based clinic hospital charity care charges incurred for services provided to individuals without health insurance or other source of third party coverage
- 2b. The dollar amount of total inpatient, outpatient, and hospital based clinic bad debt incurred by the hospital, less any recoveries for services provided to individuals without health insurance or other source of third party coverage (not including charges reported under charity care, above)
3. The dollar amount of total inpatient, outpatient, and hospital based clinic charges incurred by the hospital (includes all financial classes).

NOTES: Outpatient includes hospital outpatient services and hospital based clinic services only.

For items 2a and 2b, do not include unpaid co-pays or third party obligations of **insured patients**, contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act).

For items 2a and 2b, state or unit of local government payments made to a hospital on behalf of indigent parties (ie. Transitional Assistance and Family and Children Assistance), shall not be considered to be a form of insurance or a source of third party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included.

In the case of a new hospital, please submit the above-required information from the time your hospital began operating through the hospital's cost reporting period. Please indicate the date your hospital began operating.

FAILURE TO PROVIDE THE REQUIRED OBRA'93 INFORMATION, SEPARATED BY INPATIENT, OUTPATIENT, AND HOSPITAL BASED CLINIC CHARGES, BY AUGUST 15, 2009, MAY RESULT IN THE HOSPITAL RECEIVING A LOWER DISPROPORTIONATE SHARE RATE OR BEING INELIGIBLE FOR DISPROPORTIONATE SHARE PAYMENTS IN RATE YEAR 2010.

APPEALS

The Department will mail rate year 2010 CHAP, TCA, DSH and MPA rate notices to all cost reporting hospitals. In accordance with section 148.310 of the Illinois Administrative Code, hospitals will have thirty days from the date of the rate notice to make appeals. **All appeals must include detailed challenges to the rate. The Department cannot accept appeals submitted beyond the thirty day limit nor can it accept, as a substantive appeal, letters that only request an extension of the thirty day limit.**

SUBMITTAL OF INFORMATION

Corrected cost report information, audited certified financial statements, and the OBRA'93 data collection form must be submitted to the following address:

Illinois Department of Healthcare and Family Services
Bureau of Health Finance
Hospital Audit Section
Attention: Chris Dirks
201 South Grand Avenue East – 2nd Floor
Springfield, Illinois 62763-0001
FAX (217) 782-2812

Note: Audited certified financial statements must only be submitted if the hospital's low income utilization rate exceeds 25% for the Disproportionate Share and Medicaid Percentage Adjustment determination. Corrected cost reports must only be submitted if your hospital's 2007 cost report is unaudited and you feel it is incorrect.

All other information required for the Disproportionate Share and Medicaid Percentage Adjustment determination (obstetrical statement, and out-of-state Medicaid utilization levels) must be submitted to:

Illinois Department of Healthcare and Family Services
Bureau of Rate Development and Analysis
Disproportionate Share Unit
Attention: Kristy Pickford
201 South Grand Avenue East, 2nd Floor
Springfield, Illinois 62763-0001
FAX (217) 524-9403

Questions regarding cost report information, certified financial statements and the OBRA'93 form should be directed to the Bureau of Health Finance at (217) 782-1630. All other questions should be directed to the Bureau of Rate Development and Analysis at (217) 785-0710.



Joseph R. Holler, Chief
Bureau of Rate Development and Analysis

ATTACHMENTS

LOW INCOME UTILIZATION COLLECTION FORM
Hospital Cost Report Period Ending in 2007

Response Required by July 1, 2009
INCOMPLETE FORMS WILL BE REJECTED

Hospital: _____ **City / State:** _____

2007 Hospital Cost Reporting Period **Begin Date:** _____ **End Date:** _____, 2007

	Inpatient Amount	Outpatient Amount	Total Amount	Supporting Document
1. a. Total revenues paid the hospital for patient services under a State plan under title 19 (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity)				
Direct				
> Total claims revenue paid the hospital for patient services under Title 19 (excluding IDHFS quarterlies, assessments & TPL)	Illinois _____ Other _____	_____	_____	_____
> IDHFS quarterlies paid the hospital for patient services under Title 19	_____	_____	_____	_____
> Gross assessments paid the hospital for patient services under Title 19	Illinois _____ Other _____	_____	_____	_____
Indirect				
> Managed Care Entity revenues paid the hospital under Title 19	Illinois _____ Other _____	_____	_____	_____
Total of direct and indirect revenues paid the hospital (items 1.a.)	Total: _____	_____	_____	_____
1. b. The amount of cash subsidies for patient services received directly from State and local governments	_____	_____	_____	_____
2. Total revenues paid the hospital for patient services (including the amount of cash subsidies and assessments)				
> Total revenues paid the hospital for patient services	_____	_____	_____	_____
> Cash subsidies (reported in (1.b.) not reported in patient service revenue)	_____	_____	_____	_____
> Assessments (reported in (1.a.) not reported in patient service revenue)	_____	_____	_____	_____
Total adjusted revenues paid the hospital for patient services	Total: _____	_____	_____	_____
3. Total amount of the hospital's charges for hospital services which are attributable to charity care in a period, less cash subsidies described in (1.b.) in the period reasonably attributable to hospital services. Contractual allowance and discounts shall NOT be included (other than for indigent patients not eligible for medical assistance under a State plan under Title 19)				
> Charity Care Charges	_____	_____	_____	_____
> Less Inpatient/Outpatient Portion of Cash Subsidies Described in (1.b.)	_____	_____	_____	_____
> Net Charity Care Charges	_____	_____	_____	_____
4. Total amount of the hospital's charges for hospital services in the hospital	Total: _____	_____	_____	_____
5. Supplemental Data:				
Total revenues from other sources paid the hospital for patient services under a State plan under Title 19				
> Third party revenues paid the hospital for patient services under Title 19 (excluding Medicare payments received for dual-eligible Medicare/Medicaid crossover days)	Illinois _____ Other _____	_____	_____	_____
> Medicare revenues paid the hospital for patient services for dual eligible Medicare/Medicaid crossover claims	Illinois _____ Other _____	_____	_____	_____
I CERTIFY that to the best of my knowledge, the above information is true and correct.				
This form must be submitted to: Illinois Department of Healthcare and Family Services Bureau of Health Finance Hospital Audit Section 201 S. Grand Avenue East, 2nd Floor Springfield, Illinois 62763-0001 Phone (217)782-1630 Fax (217)782-2812			_____ Authorized Signature _____ Name (Typewritten) _____ Title (Typewritten) _____ Date _____ () Phone _____	

OBRA'93 DATA COLLECTION FORM
Hospital Cost Report Period Ending in 2007

Response Required by August 15, 2009
 INCOMPLETE FORMS WILL BE REJECTED

HOSPITAL: _____

CITY / STATE: _____

ALL COST REPORTING HOSPITALS MUST SUBMIT THE FOLLOWING INFORMATION

2007 HOSPITAL COST REPORTING PERIOD	BEGIN DATE: _____		END DATE: _____, 2007	
	INPATIENT	OUTPATIENT	HOSPITAL BASED CLINIC	TOTAL
1. Illinois Medicaid Charges: (including charges for Medicaid MCO clients)	_____	_____	_____	_____
2. a. Hospital charity care charges for services provided to individuals without health insurance or other source of third party coverage: (1) (2) (out of state hospitals provide Illinois only)	_____	_____	_____	_____
b. Hospital bad debt less any recoveries for services provided. Do not include charges reported under charity care above: (1)				
All Patients: (out of state hospitals provide Illinois only)	_____	_____	_____	_____
Insured Patients Only: (out of state hospitals provide Illinois only)	_____	_____	_____	_____
Net Bad Debt for Uninsured Patients: (2) (all patients minus insured patients)	_____	_____	_____	_____
3. Illinois Total Hospital Charges: (3)	_____	_____	_____	_____

(1) Do not include contractual allowances, or the hospital's charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act.

State or unit of local government payments made to a hospital on behalf of indigent patients (e.g., Transitional Assistance, State Family and Children Assistance) shall not be considered to be a form of insurance or a source of third party coverage. Therefore, unreimbursed charges for persons under these programs may be included.

(2) Federal law requires the collection of charity care and bad debt for uninsured patients only.

(3) Hospital charges includes all financial classes.

I CERTIFY that to the best of my knowledge the above information is true and correct.

The above information is based upon: audited financial statements and supporting schedules.
 (please check the box that applies) unaudited financial statements and supporting schedules.

This form must be submitted to:
 Illinois Department of Healthcare and Family Services
 Bureau of Health Finance
 Hospital Audit Section
 201 South Grand Avenue East - 2nd Floor
 Springfield, Illinois 62763-0001
 Phone (217)782-1630 Fax (217)782-2812

 Authorized Signature

 Name (Typewritten)

 Title (Typewritten)
 _____ ()
 Date Phone

Completion of this form or compliance with instructions is mandatory, and failure to do so may affect this Department's action. Form approved by the Forms Management Center.

**DISPROPORTIONATE SHARE OBSTETRICAL STATEMENT
RATE YEAR 2010**

COMPLETE EITHER PART I OR PART II

PART I: To be completed only by those hospitals providing non-emergency obstetrical services to the general public.

The following obstetricians have staff privileges at the hospital named below and have agreed to provide non-emergency obstetrical services for Illinois Medicaid beneficiaries:

Physician's Name: _____
(Typed)

Physician's Name: _____
(Typed)

Additional names may be submitted as an attachment to this form.

PART II: To be completed only by those hospitals that do not provide non-emergency obstetrical services to the general public.

Federal law prohibits States from making disproportionate share payment adjustments to hospitals that discontinue providing non-emergency obstetrical services to the general public after December 22, 1987. Hospitals that do not offer non-emergency obstetrical services to the general public must state so below:

_____ has not offered
(Name of Hospital)
non-emergency obstetrical services to the general public since _____.
(Date)

Return the form by July 1, 2009, to:

Illinois Department of Healthcare and Family Services
Bureau of Rate Development and Analysis
Disproportionate Share Unit
201 South Grand Avenue East, 2nd Floor
Springfield, IL 62763-0001

(Signature)

(Typed Signature)

(Title)

(Typed Hospital Name)

(Typed Address)

(Typed Address)

(Phone Number/FAX Number)

Completion of this form is voluntary; however failure to do so may affect the Department's action. Form approved by the Forms Management Center.