

201 South Grand Avenue East  
Springfield, Illinois 62763-0002

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

April 10, 2008

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, 2008, and other data must be received or postmarked no later than July 1, 2008. Data used to determine eligibility and calculate rates are not from the current period, but from either your hospital's 2006 cost reporting period (DSH and MPA) or the State's 2006 (July 1, 2006 to June 30, 2007) 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

201 South Grand Avenue East  
Springfield, Illinois 62763-0002

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TTY: (800) 526-5812

April 10, 2008

**ACTION NOTICE**

**PLEASE NOTE THE REQUIRED DEADLINES DESCRIBED BELOW**

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

RE: Rate Year 2009 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 2009. **Claims Data must be adjudicated by the Department by June 30, 2008. 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, 2008. 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 2007 (July 1, 2006 - June 30, 2007) for which claims have been received and adjudicated by June 30, 2008, will be used to determine eligibility for these payments. **Claims that have not been adjudicated by June 30, 2008 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 2006 cost reporting period statistics.**

**THIS NOTICE HAS BEEN MAILED TO THE CHIEF FINANCIAL OFFICER. PLEASE PROVIDE A COPY OF THIS NOTICE TO THE CHIEF EXECUTIVE OFFICER AND PATIENT ACCOUNT MANAGER.**

- 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, 2008.**
- 2) In making the determination, the department will utilize final audited cost reports for each hospital's 2006 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, 2008 (metered dates are not acceptable). In accordance with 89 Ill. Adm. Code 148.120(c)(1), cost report corrections received or postmarked beyond July 1, 2008, 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 MCO 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 2006 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, 2008 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 2006 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 Title XIX recipients during the hospital's 2006 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 enclosed 3835, and submit an audited certified financial statement for their 2006 cost reporting period.

**All information described in Sections 1 through 4 above is necessary to conduct the rate year 2009 disproportionate share and Medicaid percentage adjustment determination and must be received by, or postmarked to the department no later than July 1, 2008, at the address listed below. Information for Sections 1 through 4 above that is postmarked after July 1, 2008, will not be considered for the disproportionate share or Medicaid percentage adjustment determination.**

## OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

Due to new federal reimbursement guidelines, and in compliance with 305 ILCS 5/5-17(b)(1-2), the department is requiring all hospitals to file the OBRA'93 form, completed in its entirety. It is mandatory, therefore, that the following data be submitted by **all** hospitals for rate year 2009, 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, 2008 (mail postmarked on or before that date is acceptable; metered dates are not acceptable), with the following information for the hospital's 2006 cost reporting period.

1. The dollar amount of Illinois inpatient and outpatient Medicaid charges.
2. The dollar amount of total inpatient and outpatient hospital charity care charges incurred for services provided to individuals without health insurance or other source of third party coverage.
3. The dollar amount of total inpatient and outpatient 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).
4. The dollar amount of total inpatient and outpatient charges incurred by the hospital (includes all financial classes).

NOTES: Outpatient includes hospital outpatient services and hospital based clinic services only. Due to new federal guidelines, these items must be reported separately.

For items 2 and 3, 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 2 and 3, state or unit of local government payments made to a hospital on behalf of indigent parties (e.g., 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 AND OUTPATIENT CHARGES, BY AUGUST 15, 2008, MAY RESULT IN THE HOSPITAL RECEIVING A LOWER DISPROPORTIONATE SHARE RATE OR BEING INELIGIBLE FOR DISPROPORTIONATE SHARE PAYMENTS IN RATE YEAR 2009.**

## APPEALS

The Department will mail rate year 2009 CHAP, TCA, DSH and MPA rate notices to all cost reporting hospitals. In accordance with section 89 Ill. Adm. Code 148.310, 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 – 2<sup>nd</sup> 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 2006 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

**DISPROPORTIONATE SHARE OBSTETRICAL STATEMENT  
RATE YEAR 2009**

**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, 2008, 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 or compliance with instructions is voluntary; however failure to do so may affect this Department's action. Form approved by the Forms Management Center.

**LOW INCOME UTILIZATION COLLECTION FORM**  
 (Response required by July 1, 2008)

**INCOMPLETE forms will be REJECTED**

HOSPITAL: \_\_\_\_\_  
 CITY / STATE: \_\_\_\_\_  
 FISCAL YEAR END: \_\_\_\_\_, 2006

This form, in addition to audited financial statements and any other supporting documentation, must only be submitted if the hospital's low income utilization rate exceeds 25% for disproportionate share determination.

	Amount	List Attached Financial Statement or Supporting Documentation	List Workpaper Reference (i.e., pg. 1, item 1)
1. a) PAYMENTS RECEIVED DIRECTLY FROM STATE AND LOCAL GOVERNMENTS for all patient services, both inpatient and outpatient	\$ _____	_____	_____
b) GROSS ASSESSMENT PAYMENTS RECEIVED FROM IDHFS	\$ _____	_____	_____
TOTAL OF 1a) AND 1b)	=====	=====	=====
2. TOTAL HOSPITAL NET REVENUE for all patient services, both inpatient and outpatient (Gross assessment payments must be included in this amount).	\$ _____	_____	_____
3. TOTAL GROSS INPATIENT HOSPITAL CHARGES FOR CHARITY CARE (This must not include unreimbursed cost, contractual allowances, bad debts or discounts, except contractual allowances and discounts for Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent patients. Inpatient charity care charges may be calculated based on the ratio of inpatient to total gross hospital charges if the provider's records do not distinguish inpatient from total charity care).	\$ _____	_____	_____
4. TOTAL HOSPITAL GROSS CHARGES FOR INPATIENT HOSPITAL SERVICES	\$ _____	_____	_____

**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

Completion of this form or compliance with instructions is voluntary, however failure to do so may affect this Department's action.  
 Forms approved by the Forms Management Center.  
 HFS 3835 (R-9-05)

IL478-2673

**OBRA '93 DATA COLLECTION FORM**  
**(Information based upon hospital's fiscal year 2006 cost reporting period)**

(Response required by August 15, 2008)

This form will be REJECTED if not completed in its entirety.

**HOSPITAL:** \_\_\_\_\_

**CITY / STATE:** \_\_\_\_\_

**ALL COST REPORTING HOSPITALS MUST SUBMIT THE FOLLOWING INFORMATION FOR THE HOSPITAL'S**

**2006 COST REPORTING PERIOD:** BEGIN DATE: \_\_\_\_\_ END DATE: \_\_\_\_\_, 2006  
**2006 HOSPITAL FISCAL YEAR:** BEGIN DATE: \_\_\_\_\_ END DATE: \_\_\_\_\_, 2006

	INPATIENT	OUTPATIENT (1)	TOTAL
<b>1. Illinois Medicaid Charges:</b> (excluding charges for Medicaid MCO clients)	_____	_____	_____
<b>2. a. Hospital charity care charges for services provided to individuals without health insurance or other source of third party coverage: (2) (3)</b> (out of state hospitals provide Illinois only)	_____	_____	_____
<b>b. Hospital bad debt less any recoveries for services provided. Do not include charges reported under charity care above: (2)</b>	_____	_____	_____
<b>All Patients:</b> (out of state hospitals provide Illinois only)	_____	_____	_____
<b>Insured Patients Only:</b> (out of state hospitals provide Illinois only)	_____	_____	_____
<b>Net Bad Debt for Uninsured Patients: (3)</b> (all patients minus insured patients)	_____	_____	_____
<b>3. Illinois Total Hospital Charges: (4)</b>	_____	_____	_____

(1) Includes hospital outpatient services and hospital based clinic services only -please report these two items separately.

(2) 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 covered under these programs may be included.

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

(4) 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