

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 1) Heading of the Part: Hospital Services
- 2) Code Citation: 89 Ill. Adm. Code 148
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
148.70	Amendment
148.117	Amendment
148.126	Amendment
148.140	Amendment
148.190	Amendment
148.240	Amendment
148.285	Repeal
148.295	Amendment
148.458	Amendment
148.510	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date: July 1, 2012
- 6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: This emergency rule expires, as authorized by the SMART Act, on June 30, 2013.
- 7) Date Filed with the Index Department: June 29, 2012
- 8) A copy of the emergency amendment, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: Public Act 97-0689, Save Medicaid Access and Resources Together (SMART) Act, gives any agency in charge with implementing a provision or initiative in SMART, the ability to adopt rules through emergency rulemaking in order to provide for the expeditious and timely implementation of SMART. The adoption of this emergency rulemaking is deemed to be necessary for the public interest, safety, and welfare. Pursuant to Public Act 97-0689, the 150-day limitation of the effective period of emergency rules does not apply and the effective period of rules necessary to implement SMART may continue through June 30, 2013. These emergency rules are necessary to implement the provisions and initiatives of SMART.
- 10) Complete Description of the Subjects and Issues Involved: These administrative

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

rules are authorized by SMART which mandates adjustments to co-pays and any rate of reimbursement for services or other payments or alteration of any methodologies authorized by the Public Aid Code to reduce any rate of reimbursement for services or other payments.

- 11) Are there any other proposed rulemakings pending on this Part? Yes

<u>Section</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
148.70	Amendment	36 Ill. Reg. 8117; June 1, 2012

- 12) Statement of Statewide Policy Objectives: These emergency amendments neither create nor expand any State mandate, affecting units of local government.

- 13) Information and questions regarding these emergency amendments shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233

The full text of the Emergency Amendments begins on the next page:

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 148

HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS

Section

- 148.10 Hospital Services
- 148.20 Participation
- 148.25 Definitions and Applicability
- 148.30 General Requirements
- 148.40 Special Requirements
- 148.50 Covered Hospital Services
- 148.60 Services Not Covered as Hospital Services
- 148.70 Limitation On Hospital Services

EMERGENCY

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section

- 148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
- 148.82 Organ Transplant Services
- 148.85 Supplemental Tertiary Care Adjustment Payments
- 148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments
- 148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments
- 148.100 Outpatient Rural Hospital Adjustment Payments
- 148.103 Outpatient Service Adjustment Payments
- 148.105 Psychiatric Adjustment Payments
- 148.110 Psychiatric Base Rate Adjustment Payments
- 148.112 High Volume Adjustment Payments
- 148.115 Rural Adjustment Payments
- 148.117 Outpatient Assistance Adjustment Payments

EMERGENCY

- 148.120 Disproportionate Share Hospital (DSH) Adjustments
- 148.122 Medicaid Percentage Adjustments
- 148.126 Safety Net Adjustment Payments

EMERGENCY

- 148.130 Outlier Adjustments for Exceptionally Costly Stays

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 148.140 Hospital Outpatient and Clinic Services
EMERGENCY
- 148.150 Public Law 103-66 Requirements
- 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million
- 148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
- 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act
- 148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
- 148.190 Copayments
EMERGENCY
- 148.200 Alternate Reimbursement Systems
- 148.210 Filing Cost Reports
- 148.220 Pre September 1, 1991, Admissions
- 148.230 Admissions Occurring on or after September 1, 1991
- 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
EMERGENCY
- 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
- 148.260 Calculation and Definitions of Inpatient Per Diem Rates
- 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
- 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
- 148.285 Excellence in Academic Medicine Payments (Repealed)
EMERGENCY
- 148.290 Adjustments and Reductions to Total Payments
- 148.295 Critical Hospital Adjustment Payments (CHAP)
EMERGENCY
- 148.296 Tertiary Care Adjustment Payments
- 148.297 Pediatric Outpatient Adjustment Payments
- 148.298 Pediatric Inpatient Adjustment Payments
- 148.300 Payment
- 148.310 Review Procedure
- 148.320 Alternatives
- 148.330 Exemptions
- 148.340 Subacute Alcoholism and Substance Abuse Treatment Services

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 148.350 Definitions (Repealed)
- 148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.368 Volume Adjustment (Repealed)
- 148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services
- 148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
- 148.390 Hearings
- 148.400 Special Hospital Reporting Requirements
- 148.402 Medicaid Eligibility Payments (Repealed)
- 148.404 Medicaid High Volume Adjustment Payments (Repealed)
- 148.406 Intensive Care Adjustment Payments (Repealed)
- 148.408 Trauma Center Adjustment Payments (Repealed)
- 148.410 Psychiatric Rate Adjustment Payments (Repealed)
- 148.412 Rehabilitation Adjustment Payments (Repealed)
- 148.414 Supplemental Tertiary Care Adjustment Payments (Repealed)
- 148.416 Crossover Percentage Adjustment Payments (Repealed)
- 148.418 Long Term Acute Care Hospital Adjustment Payments (Repealed)
- 148.420 Obstetrical Care Adjustment Payments (Repealed)
- 148.422 Outpatient Access Payments (Repealed)
- 148.424 Outpatient Utilization Payments (Repealed)
- 148.426 Outpatient Complexity of Care Adjustment Payments (Repealed)
- 148.428 Rehabilitation Hospital Adjustment Payments (Repealed)
- 148.430 Perinatal Outpatient Adjustment Payments (Repealed)
- 148.432 Supplemental Psychiatric Adjustment Payments (Repealed)
- 148.434 Outpatient Community Access Adjustment Payments (Repealed)
- 148.440 High Volume Adjustment Payments
- 148.442 Inpatient Services Adjustment Payments
- 148.444 Capital Needs Payments
- 148.446 Obstetrical Care Payments
- 148.448 Trauma Care Payments
- 148.450 Supplemental Tertiary Care Payments
- 148.452 Crossover Care Payments
- 148.454 Magnet Hospital Payments
- 148.456 Ambulatory Procedure Listing Increase Payments
- 148.458 General Provisions
- EMERGENCY
- 148.460 Catastrophic Relief Payments
- 148.462 Hospital Medicaid Stimulus Payments

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

Section

148.500 Definitions
148.510 Reimbursement

EMERGENCY

SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section

148.600 Definitions
148.610 Scope of the Program
148.620 Assistance Level and Reimbursement
148.630 Criteria and Information Required to Establish Eligibility
148.640 Covered Services

SUBPART E: INSTITUTION FOR MENTAL DISEASES PROVISIONS FOR HOSPITALS

Section

148.700 General Provisions

148.TABLE A Renal Participation Fee Worksheet
148.TABLE B Bureau of Labor Statistics Equivalence
148.TABLE C List of Metropolitan Counties by SMSA Definition

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992;

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000;

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of 150 days; emergency expired June 7, 2004; amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7101, effective May 3, 2004; amended at 28 Ill. Reg. 8072, effective June 1, 2004; emergency amendment at 28 Ill. Reg. 8167, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9661, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10157, effective July 1, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12036, effective August 3, 2004, for a maximum of 150 days; emergency expired December 30, 2004; emergency amendment at 28 Ill. Reg. 12227, effective August 6, 2004, for a maximum of 150 days; emergency expired January 2, 2005; amended at 28 Ill. Reg. 14557, effective October 27, 2004; amended at 28 Ill. Reg. 15536, effective November 24, 2004; amended at 29 Ill. Reg. 861,

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2026, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; amended at 30 Ill. Reg. 383, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 955, effective January 9, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 2827, effective February 24, 2006; emergency amendment at 30 Ill. Reg. 7786, effective April 10, 2006, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 12400, effective July 1, 2006, for the remainder of the 150 days; emergency expired September 6, 2006; amended at 30 Ill. Reg. 8877, effective May 1, 2006; amended at 30 Ill. Reg. 10393, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18672, effective November 27, 2006; emergency amendment at 31 Ill. Reg. 1602, effective January 1, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 1997, effective January 15, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 5596, effective April 1, 2007; amended at 31 Ill. Reg. 8123, effective May 30, 2007; amended at 31 Ill. Reg. 8508, effective June 1, 2007; emergency amendment at 31 Ill. Reg. 10137, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11688, effective August 1, 2007; amended at 31 Ill. Reg. 14792, effective October 22, 2007; amended at 32 Ill. Reg. 312, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 518, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 2993, effective February 16, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8718, effective May 29, 2008; amended at 32 Ill. Reg. 9945, effective June 26, 2008; emergency amendment at 32 Ill. Reg. 10517, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 33 Ill. Reg. 501, effective December 30, 2008; peremptory amendment at 33 Ill. Reg. 1538, effective December 30, 2008; emergency amendment at 33 Ill. Reg. 5821, effective April 1, 2009, for a maximum of 150 days; emergency expired August 28, 2009; amended at 33 Ill. Reg. 13246, effective September 8, 2009; emergency amendment at 34 Ill. Reg. 15856, effective October 1, 2010, for a maximum of 150 days; emergency expired February 27, 2011; amended at 34 Ill. Reg. 17737, effective November 8, 2010; amended at 35 Ill. Reg. 420, effective December 27, 2010; amended at 35 Ill. Reg. 10033, effective June 15, 2011; emergency amendment at 36 Ill. Reg. _____, effective July 1, 2012, for a maximum of 365 days.

SUBPART A: GENERAL PROVISIONS

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

Section 148.70 Limitation On Hospital Services

EMERGENCY

Formatted: Font: Bold

- a) Payment for inpatient hospital care in general and specialty hospitals, including psychiatric hospitals, shall be made only when it is recommended by a qualified physician, and the care is essential as determined by the appropriate utilization review authority. For hospitals or distinct part units reimbursed on a per diem basis under Sections 148.160 through 148.170 and 148.250 through 148.300, payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority (see Section 148.240). If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.
- b) For hospitals or distinct part units reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code Part 149.
- c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.160 through 148.170 and 148.250 through 148.300, payment for inpatient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.
- d) In obstetrical cases, payment for services to both the mother and the newborn child shall be made at one per diem rate, or one per case rate, whichever is applicable. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name separately.
- e) Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1), shall be made only when such services have been provided in accordance with federal regulations at 42 CFR 441, Subparts C and D.
- f) Payment for transplantation costs (with the exception of kidney and cornea transplants), including organ acquisition costs, shall be made only when provided by an approved transplantation center as described in Section 148.82. Payment for kidney and cornea transplantation costs does not require enrollment as an

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

approved transplantation center and is only provided to hospitals reimbursed on a per case basis in accordance with 89 Ill. Adm. Code 149.

g) Effective with inpatient admissions on and after July 1, 2012, and pursuant to the SMART Act (P.A. 97-0689), the Department will deny payment to hospitals for the entire inpatient stay if a designated Provider-Preventable Condition (PPC) presents during the inpatient admission. This policy applies to all hospitals. Provider-Preventable Conditions are those conditions or events that are considered reasonably preventable through compliance with evidence-based guidelines. For the category of PPCs defined as Hospital-Acquired Conditions (HACs), hospitals are required to code inpatient claims with a Present on Admission (POA) indicator for principal and secondary diagnosis codes billed. The POA indicator will identify if the condition was introduced after the inpatient admission. The Department will specify to hospitals the list of diagnosis codes or diagnosis/procedure code combinations that will be used as HACs via provider releases and posting on the Department's Web site. For the category of PPCs defined as Other Provider Preventable Conditions (OPPCs), the Department will deny payment for claims relating to a wrong surgical procedure performed on a patient; a surgical procedure performed on the wrong body part; or a surgical procedure performed on the wrong patient. Hospitals must submit claims to report these incidents and will be instructed to populate the inpatient claims with specific supplementary diagnosis coding.

Formatted: Font: 12 pt
Formatted: Indent: Left: 0.5", Hanging: 0.5"
Formatted: Font: 12 pt
Formatted: Font: 12 pt
Formatted: Font: 12 pt

h) Payment for caesarean sections shall be at the normal vaginal delivery rate unless a caesarean section is medically necessary.

Formatted: Indent: Hanging: 0.25"
Formatted: Indent: Left: 0.5", Hanging: 0.5"

(Source: Emergency amended at 36 Ill. Reg. ____, effective July 1, 2012, for a maximum of 365 days)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.117 Outpatient Assistance Adjustment Payments

EMERGENCY

- a) Qualifying Criteria. Outpatient Assistance Adjustment Payments, as described in subsection (b) of this Section, shall be made to Illinois hospitals meeting one of the criteria identified in this subsection (a):
 - 1) A hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

percentage greater than 70% and has provided greater than 10,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

- 2) A general acute care hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care percentage greater than 85%.
- 3) A general acute care hospital that does not qualify for Medicaid Percentage Adjustment Payments for rate year 2007, as defined in Section 148.122, located in Cook County, outside the City of Chicago, has an emergency care percentage greater than 63%, has provided more than 10,750 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year and has provided more than 325 Medicaid surgical group outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 4) A general acute care hospital located outside of Cook County that qualifies for Medicaid Percentage Adjustment Payments for rate year 2007 as defined in Section 148.122, is a trauma center recognized by the Illinois Department of Public Health (DPH) as of July 1, 2006, has an emergency care percentage greater than 58%, and has provided more than 1,000 Medicaid Non-emergency/Screening outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 5) A hospital that has an MIUR of greater than 50% and an emergency care percentage greater than 80%, and that provided more than 6,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 6) A hospital that has an MIUR of greater than 70% and an emergency care percentage greater than 90%.
- 7) A general acute care hospital, not located in Cook County, that is not a trauma center recognized by DPH as of July 1, 2006 and did not qualify for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an MIUR of greater than 25% and an emergency care percentage greater than 50%, and that provided more than 8,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 8) A general acute care hospital, not located in Cook County, that is a Level I trauma center recognized by DPH as of July 1, 2006, has an emergency care percentage greater than 50%, and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services, including more than 1,000 non-emergency screening outpatient ambulatory procedure listing services, in the outpatient assistance base year.
- 9) A general acute care hospital, not located in Cook County, that qualified for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an emergency care percentage greater than 55%, and provided more than 12,000 Medicaid outpatient ambulatory procedure listing services, including more than 600 surgical group outpatient ambulatory procedure listing services and 7,000 emergency services in the outpatient assistance base year.
- 10) A general acute care hospital that has an emergency care percentage greater than 75% and provided more than 15,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 11) A rural hospital that has an MIUR of greater than 40% and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 12) A general acute care hospital, not located in Cook County, that is a trauma center recognized by DPH as of July 1, 2006, had more than 500 licensed beds in calendar year 2005, and provided more than 11,000 Medicaid outpatient ambulatory procedure listing services, including more than 950 surgical group outpatient ambulatory procedure listing services, in the outpatient assistance base year.
- 13) A general acute care hospital located outside of Illinois that provided more than 300 high tech diagnostic Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.
- 14) A general acute care hospital is recognized as a Level I trauma center by DPH on the first day of the OAAP rate period, has Emergency Level I services greater than 2,000, Emergency Level II services greater than 8,000, and greater than 19,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- b) Outpatient Assistance Adjustment Payments
- 1) For hospitals qualifying under subsection (a)(1), the rate is \$139.00.
 - 2) For hospitals qualifying under subsection (a)(2), the rate is \$850.00.
 - 3) For hospitals qualifying under subsection (a)(3), the rate is \$425.00.
 - 4) For hospitals qualifying under subsection (a)(4), the rate is \$665.00 through ~~December 31, 2014~~June 30, 2012. For dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$375.00.
 - 5) For hospitals qualifying under subsection (a)(5), the rate is \$250.00.
 - 6) For hospitals qualifying under subsection (a)(6), the rate is \$336.25.
 - 7) For hospitals qualifying under subsection (a)(7), the rate is \$110.00.
 - 8) For hospitals qualifying under subsection (a)(8), the rate is \$200.00.
 - 9) For hospitals qualifying under subsection (a)(9), the rate is \$128.50 through June 30, 2010. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~June 30, 2012, this rate shall be increased by \$74.00, to \$202.50. For dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$48.50.
 - 10) For hospitals qualifying under subsection (a)(10), the rate is \$135.00. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~June 30, 2012, this rate shall be increased by \$70.00, to \$205.00. For dates of service on or after January 1, 2015, the rate is \$135.00.
 - 11) For hospitals qualifying under subsection (a)(11), the rate is \$65.00.
 - 12) For hospitals qualifying under subsection (a)(12), the rate is \$90.00.
 - 13) For hospitals qualifying under subsection (a)(13) that have an emergency care percentage greater than 19% but less than 25%, the rate is \$141.00. For hospitals qualifying under subsection (a)(13) that have an emergency care percentage greater than 25%, the rate is \$494.00.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 14) For hospitals qualifying under subsection (a)(14), the rate is \$47.00 for dates of service on or after July 1, 2010 through ~~December 31, 2014~~ June 30, 2012. For dates of service on or after ~~January 1, 2015~~ July 1, 2012, the rate is \$0.00.
- c) Payment to a Qualifying Hospital
- 1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by the Medicaid outpatient ambulatory procedure listing services in the outpatient assistance adjustment base year.
 - 2) For the outpatient assistance adjustment period for fiscal year 2010 and after, total payments will equal the amount determined using the methodologies described in subsection (c)(1) of this Section and shall be paid to the hospital, at least, on a quarterly basis.
 - 3) Payments described in this Section are subject to federal approval.
- d) Definitions
- 1) "Emergency care percentage" means a fraction, the numerator of which is the total Group 3 ambulatory procedure listing services as described in Section 148.140(b)(1)(C), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006, and the denominator of which is the total ambulatory procedure listing services as described in Section 148.140(b)(1), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006.
 - 2) "General acute care hospital" is a hospital that does not meet the definition of a hospital contained in 89 Ill. Adm. Code 149.50(c).
 - 3) "Outpatient Ambulatory Procedure Listing Payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.

- 4) "Outpatient assistance year" means, beginning January 1, 2007, the 6-month period beginning on January 1, 2007 and ending June 30, 2007, and beginning July 1, 2007, the 12-month period beginning July 1 of the year and ending June 30 of the following year.
 - 5) "Outpatient assistance base period" means the 12-month period beginning on July 1, 2004 and ending June 30, 2005.
 - 6) "Surgical group outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(A), excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.
 - 7) "Non-emergency/screening outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(C)(iii), excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.
 - 8) "High tech diagnostic Medicaid outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services described in Section 148.140(b)(1)(B)(ii), excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.
- e) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

as defined in 305 ILCS 5/5-30 must be a Coordinated Care Participating Hospital as defined in Section 148.295(g)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.

(Source: Emergency amended at 36 Ill. Reg._____, effective July 1, 2012 for a maximum of 365 days)

Section 148.126 Safety Net Adjustment Payments

EMERGENCY

Formatted: Font: Bold

- a) Qualifying criteria: Safety net adjustment payments shall be made to a qualifying hospital, as defined in this subsection (a), unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria:
- 1) The hospital has, as provided in subsection (e)(6) of this Section, an MIUR equal to or greater than 40 percent.
 - 2) The hospital has the highest number of obstetrical care days in the safety net hospital base year.
 - 3) The hospital is, as of October 1, 2001, a sole community hospital, as defined by the United States Department of Health and Human Services (42 CFR 412.92).
 - 4) The hospital is, as of October 1, 2001, a rural hospital, as described in Section 148.25(g)(3); that meets all of the following criteria:
 - A) Has an MIUR greater than 33 percent.
 - B) Is designated a perinatal level two center by the Illinois Department of Public Health.
 - C) Has fewer than 125 licensed beds.
 - 5) The hospital is a rural hospital, as described in Section 148.25(g)(3).

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 6) The hospital meets all of the following criteria:
 - A) Has an MIUR greater than 30 percent.
 - B) Had an occupancy rate greater than 80 percent in the safety net hospital base year.
 - C) Provided greater than 15,000 total days in the safety net hospital base year.
- 7) The hospital meets all of the following criteria:
 - A) Does not already qualify under subsections (a)(1) through (a)(6) of this Section.
 - B) Has an MIUR greater than 25 percent.
 - C) Had an occupancy rate greater than 68 percent in the safety net hospital base year.
 - D) Provided greater than 12,000 total days in the safety net hospital base year.
- 8) The hospital meets all of the following criteria in the safety net base year:
 - A) Is a rural hospital, as described in Section 148.25(g)(3).
 - B) Has an MIUR greater than 18 percent.
 - C) Has a combined MIUR greater than 45 percent.
 - D) Has licensed beds less than or equal to 60.
 - E) Provided greater than 400 total days.
 - F) Provided fewer than 125 obstetrical care days.
- 9) The hospital meets all of the following criteria in the safety net base year:
 - A) Is a psychiatric hospital, as described in 89 Ill. Adm. Code 149.50(c)(1).

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- B) Has licensed beds greater than 120.
 - C) Has an average length of stay less than ten days.
- 10) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(9) of this Section.
 - B) Has an MIUR greater than 17 percent.
 - C) Has licensed beds greater than 450.
 - D) Has an average length of stay less than four days.
- 11) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(10) of this Section.
 - B) Has an MIUR greater than 21 percent.
 - C) Has licensed beds greater than 350.
 - D) Has an average length of stay less than 3.15 days.
- 12) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(11) of this Section.
 - B) Has an MIUR greater than 34 percent.
 - C) Has licensed beds greater than 350.
 - D) Is designated a perinatal Level II center by the Illinois Department of Public Health.
- 13) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(12) of this Section.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- B) Has an MIUR greater than 35 percent.
 - C) Has an average length of stay less than four days.
- 14) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(13) of this Section.
 - B) Has a Combined MIUR greater than 25 percent.
 - C) Has an MIUR greater than 12 percent.
 - D) Is designated a perinatal Level II center by the Illinois Department of Public Health.
 - E) Has licensed beds greater than 400.
 - F) Has an average length of stay less than 3.5 days.
- 15) A hospital provider that would otherwise be excluded from payment by subsection (a) because it does not operate a comprehensive emergency room, if the hospital provider operates within 1 mile of an affiliate hospital provider that is owned and controlled by the same governing body that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), and the provider operates a standby emergency room, as defined in 77 Ill. Adm. Code 250.710(c), and functions as an overflow emergency room for its affiliate hospital provider.
- 16) The hospital has an MIUR greater than 90% in the safety net hospital base year.
- 17) The hospital meets all of the following criteria in the safety net base year:
- A) Does not already qualify under subsections (a)(1) through (a)(16) of this Section.
 - B) Is located outside HSA 6.
 - C) Has an MIUR greater than 16%.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- D) Has licensed beds greater than 475.
- E) Has an average length of stay less than five days.
- 18) The hospital meets all of the following criteria in the safety net base year:
 - A) Provided greater than 5,000 obstetrical care days.
 - B) Has a combined MIUR greater than 80%.
- 19) The hospital meets all of the following criteria in the safety net base year:
 - A) Does not already qualify under subsections (a)(1) through (a)(18) of this Section.
 - B) Has a CMIUR greater than 28 percent.
 - C) Is designated a perinatal Level II center by the Illinois Department of Public Health.
 - D) Has licensed beds greater than 320.
 - E) Had an occupancy rate greater than 37 percent in the safety net hospital base year.
 - F) Has an average length of stay less than 3.1 days.
- 20) The hospital meets all of the following criteria in the safety net base year:
 - A) Does not already qualify under subsections (a)(1) through (a)(19) of this Section.
 - B) Is a general acute care hospital.
 - C) Is designated a perinatal Level II center by the Illinois Department of Public Health.
 - D) Provided greater than 1,000 rehabilitation days in the safety net hospital base year.
- b) The following five classes of hospitals are ineligible for safety net adjustment

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4), subsections (a)(6) through (a)(8), subsections (a)(10) through (a)(15) and subsections (a)(17) through (a)(19) of this Section:

- 1) Hospitals located outside of Illinois.
 - 2) County-owned hospitals, as described in Section 148.25(b)(1)(A).
 - 3) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).
 - 4) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).
 - 5) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(c)(4).
- c) Safety Net Adjustment Rates
- 1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:
 - A) A qualifying hospital – \$15.00.
 - B) A rehabilitation hospital, as described in 89 Ill. Adm. Code 149.50(c)(2) – \$20.00.
 - C) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(3) – \$20.00.
 - D) A children's hospital that has an MIUR greater than or equal to 80 per centum that is:
 - i) Located within HSA 6 or HSA 7 – \$296.00.
 - ii) Located outside HSA 6 or HSA 7 – \$35.00.
 - E) A children's hospital that has an MIUR less than 80 per centum, but greater than or equal to 60 per centum, that is:
 - i) Located within HSA 6 or HSA 7 – \$35.00.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- ii) Located outside HSA 6 or HSA 7 – \$15.00.
- F) A children's hospital that has an MIUR less than 60 per centum, but greater than or equal to 45 per centum, that is:
 - i) Located within HSA 6 or HSA 7 – \$12.00.
 - ii) Located outside HSA 6 or HSA 7 – \$5.00.
- G) A children's hospital with more than 25 graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory" – \$160.25.
- H) A children's hospital that is a rural hospital – \$145.00.
- D) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital that is located in HSA 6 and that:
 - i) Provides obstetrical care – \$10.00.
 - ii) Has at least one graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – \$5.00.
 - iii) Has at least one obstetrical graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – \$5.00.
 - iv) Provided more than 5,000 obstetrical days during the safety net hospital base year – \$35.00.
 - v) Provided fewer than 4,000 obstetrical days during the safety net hospital base year and its average length of stay is: less than or equal to 4.50 days – \$5.00; less than 4.00 days – \$5.00; less than 3.75 days – \$5.00.
 - vi) Provides obstetrical care and has an MIUR greater than 65 percent – \$11.00.
 - vii) Has greater than 700 licensed beds – \$37.75.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- J) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6; that has an MIUR greater than 50 per centum, and that:
- i) Provides obstetrical care – \$280.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$70.00.
 - ii) Does not provide obstetrical care – \$120.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$30.00.
 - iii) Is a trauma center, recognized by the Illinois Department of Public Health (DPH), as of July 1, 2005 – \$173.50.
- K) A qualifying hospital that provided greater than 35,000 total days in the safety net hospital base year – \$43.25.
- L) A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory", with an average length of stay fewer than 4.00 days – \$48.00.
- 2) For a hospital qualifying under subsection (a)(2) of this Section, the rate shall be \$123.00.
- 3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:
- A) A qualifying hospital – \$40.00.
 - B) A hospital that has an average length of stay of fewer than 4.00 days, and:
 - i) More than 150 licensed beds – \$20.00.
 - ii) Fewer than 150 licensed beds – \$40.00.
 - C) A qualifying hospital with the lowest average length of stay –

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

\$15.00.

- D) A hospital that has a CMIUR greater than 65 per centum – \$35.00.
- E) A hospital that has fewer than 25 total admissions in the safety net hospital base year – \$160.00.
- 4) For a hospital qualifying under subsection (a)(4) of this Section, the rate shall be \$110.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$55.00.
- 5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is the sum of the amounts for each of the following for which it qualifies, divided by the hospital's total days:
 - A) The hospital that has the highest number of obstetrical care admissions – \$30,840.00.
 - B) The greater of:
 - i) The product of \$115.00 multiplied by the number of obstetrical care admissions.
 - ii) The product of \$11.50 multiplied by the number of general care admissions.
- 6) For a hospital qualifying under subsection (a)(6) of this Section, the rate is \$56.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$53.00.
- 7) For a hospital qualifying under subsection (a)(7) of this Section, the rate is \$315.50 through ~~December 31, 2014~~ ~~June 30, 2012~~ if federal approval is received by the Department for that rate; otherwise, the rate shall be \$210.50. For dates of service on or after ~~January 1, 2015~~ ~~July 1, 2012~~, the rate is \$210.50.
- 8) For a hospital qualifying under subsection (a)(8) of this Section, the rate is \$124.50.
- 9) For a hospital qualifying under subsection (a)(9) of this Section, the rate is

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

\$133.00. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~~~June 30, 2012~~, this rate shall be increased by \$72.00, to \$205.00. For dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$85.50.

- 10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is \$13.75. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~~~June 30, 2012~~, this rate shall be increased by \$25.00, to \$38.75. For dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$13.75.
- 11) For a hospital qualifying under subsection (a)(11) of this Section, the rate is \$421.00 through ~~December 31, 2014~~~~June 30, 2012~~. For dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$39.50.
- 12) For a hospital qualifying under subsection (a)(12) of this Section, the rate is \$240.50 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$120.25.
- 13) For a hospital qualifying under subsection (a)(13) of this Section, for dates of service on or after April 1, 2009, the rate is \$815.00.
- 14) For a hospital qualifying under subsection (a)(14) of this Section, the rate is \$443.75 if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$343.75.
- 15) For a hospital qualifying under subsection (a)(16) of this Section, the rate is \$39.50.
- 16) For a hospital qualifying under subsection (a)(17) of this Section, the rate is \$69.00. This reimbursement rate is contingent on federal approval.
- 17) For a hospital qualifying under subsection (a)(18) of this Section, the rate is \$56.00 through ~~December 31, 2014~~~~June 30, 2012~~. For dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$16.00. This reimbursement rate is contingent on federal approval.
- 18) For a hospital qualifying under subsection (a)(19) of this Section, the rate is \$229.00. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~~~June 30, 2012~~, this rate shall be increased by \$113.00,

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

to \$342.00. For dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$145.00.

- 19) For a hospital qualifying under subsection (a)(20) of this Section, the rate is \$71.00 through ~~December 31, 2014~~June 30, 2012. For dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$0.00.

d) Payment to a Qualifying Hospital

- 1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by two multiplied by total days.
- 2) For the safety net adjustment period occurring in State fiscal year 2011, total payments will be determined through application of the methodologies described in subsection (c) of this Section.
- 3) For safety net adjustment periods occurring after State fiscal year 2010, total payments made under this Section shall be paid in installments on, at least, a quarterly basis.

e) Definitions

- 1) "Average length of stay" means, for a given hospital, a fraction in which the numerator is the number of total days and the denominator is the number of total admissions.
- 2) "CMIUR" means, for a given hospital, the sum of the MIUR plus the Medicaid obstetrical inpatient utilization rate, determined as of October 1, 2001, as defined in Section 148.120(i)(6).
- 3) "General care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department by June 30, 2001, excluding admissions for: obstetrical care, as defined in subsection (e)(7) of this Section; normal newborns; psychiatric care; physical rehabilitation; and those covered in whole or in part by Medicare (Medicaid/Medicare crossover admissions).

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 4) "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.
- 5) "Licensed beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."
- 6) "MIUR", for a given hospital, has the meaning as defined in Section 148.120(i)(5) and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for safety net adjustment payments in the Safety Net Adjustment Period.
- 7) "Obstetrical care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data, for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001, and were assigned by the Department a diagnosis related grouping (DRG) code of 370 through 375.
- 8) "Obstetrical care days" means, for a given hospital, days of hospital inpatient service associated with the obstetrical care admissions described in subsection (e)(7) of this Section.
- 9) "Occupancy rate" means, for a given hospital, a fraction, the numerator of which is the hospital's total days, excluding long term care and substance abuse days, and the denominator of which is the hospital's total beds, excluding long term care and substance abuse beds, multiplied by 365 days. The data used for calculation of the hospital occupancy rate is as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".
- 10) "Safety net hospital base year" means the 12-month period beginning on July 1, 1999, and ending on June 30, 2000.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 11) "Safety net adjustment period" means, beginning July 1, 2002, the 12 month period beginning on July 1 of a year and ending on June 30 of the following year.
 - 12) "Total admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.
 - 13) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.
- f) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 must be a Coordinated Care Participating Hospital as defined in Section 148.295(g)(5). The payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.

(Source: Emergency amended at 36 Ill. Reg._____, effective July 1, 2012, for a maximum of 365 days)

Section 148.140 Hospital Outpatient and Clinic Services

EMERGENCY

- a) Fee-For-Service Reimbursement
 - 1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:

Formatted: Font: Bold

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- A) Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection (b) of this Section.
 - B) End stage renal disease treatment (ESRDT) services, as described in subsection (c) of this Section.
 - C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D).
 - D) Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section.
- 2) Except for the procedures under the APL groupings described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.
- 3) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
- A) The reimbursement rates described in subsection (a)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
 - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 4) Maternal and Child Health Program rates, as described in 89 Ill. Adm. Code 140, Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), and Section 148.25(b)(5)(C). Maternal and Child Health Program rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Maternal and Child Health Program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).
 - 5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.
 - 6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
 - 7) With the exception of the retrospective adjustment described in subsection (a)(3) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section.
- b) Ambulatory Procedure Listing (APL)
Effective ~~January 1, 2006~~ July 1, 2012, the Department will reimburse hospitals for certain hospital outpatient procedures as described in subsection (b)(1) of this Section.
- 1) APL Groupings
Under the APL, a list was developed that defines those technical procedures that require the use of the hospital outpatient setting, its technical staff or equipment. These procedures are separated into separate groupings based upon the complexity and historical costs of the procedures. The groupings are as follows:
 - A) Surgical Groups

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- i) Surgical group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment. The rate for this surgical procedure group shall be \$1,794.00.
- ii) Surgical group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate for this surgical procedure group shall be \$1,049.00.
- iii) Surgical group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for this surgical procedure group shall be \$752.00.
- iv) Surgical group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. Certain dental procedures performed by dentists are included in this group. In order for a dental procedure to be eligible for reimbursement in the outpatient setting, the following criteria must be met: patient requires general anesthesia or conscious sedation; patient has a medical condition that places the patient at an increased surgical risk, such as, but not limited to, cardiopulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or the patient cannot be safely managed in an office setting because of behavioral, developmental, or mental disorder. The rate for this surgical procedure group shall be \$287.00.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- B) Diagnostic and Therapeutic Groups
- i) Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician. The rate for this surgical procedure group shall be \$941.00.
 - ii) Diagnostic and therapeutic group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study. The rate for this procedure group shall be \$304.00.
 - iii) Diagnostic and therapeutic group 2(c) consists of other diagnostic tests. Group 2(c) procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate for this procedure group shall be \$176.00.
 - iv) Diagnostic and therapeutic group 2(d) consists of therapeutic procedures. Group 2(d) procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures. The rate for this procedure group shall be \$136.00.
- C) Group 3 reimbursement for services provided in a hospital emergency department will be made in accordance with one of the three levels described in this Section. Emergency Services mean those services that are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The determination of the level of service

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

reimbursable by the Department shall be based upon the circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.

- i) Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function or requires an intense level of physician or nursing intervention. An "intense level" is defined as more than two hours of documented one-on-one nursing care or interactive treatment. The rate for this service shall be \$181.00.
 - ii) Emergency Level II refers to Emergency Services that do not meet the definition in this Section of Emergency Level I care, but that are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity. The rate for this service shall be \$67.00.
 - iii) Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Level I or II stated in this Section. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided or a screening fee, but not both. The rate for this service shall be \$26.00.
- D) Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting that provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories:

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- i) for at least 60 minutes but less than six hours and 31 minutes of services, the rate shall be \$74.00;
- ii) for at least six hours and 31 minutes but less than 12 hours and 31 minutes of services, the rate shall be \$222.00; or
- iii) for at least 12 hours and 31 minutes or more of services, the rate shall be \$443.00.

E) Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse, at different rates, Type A and Type B Psychiatric Clinic Services, as defined in Section 148.40(d)(1). A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).

- i) The rate for Type A psychiatric clinic services shall be \$68.00.
- ii) The rate for Type A psychiatric clinic services provided by a Children's Hospital shall be \$102.00.
- iii) The rate for Type B psychiatric clinic services shall be \$101.00.
- iv) The rate for Type B psychiatric clinic services provided by a Children's Hospital shall be \$102.00.

~~F) Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services. Under this group, the Department will reimburse for services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation services at a different rate than will be reimbursed for physical rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation services. A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).~~

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- i) ~~The rate for rehabilitation services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00.~~
- ii) ~~The rate for rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation shall be \$115.00.~~
- iii) ~~The rate for rehabilitation services provided by Children's Hospitals shall be \$130.00.~~

- 2) Each of the groups described in subsection (b)(1) of this Section will be reimbursed by the Department considering the following:
 - A) The Department will provide cost outlier payments for specific devices and drugs associated with specific APL procedures. Such payments will be made if:
 - i) The device or drug is on an approved list maintained by the Department. In order to be approved, the Department will consider requests from medical providers and shall base its decision on medical appropriateness of the device or drug and the costs of such device or drug; and
 - ii) The provision of such devices or drugs is deemed to be medically appropriate for a specific client, as determined by the Department's physician consultants.
 - B) Additional payment for such devices or drugs, as described in subsection (b)(2)(A) of this Section, will require prior authorization by the Department unless it is determined by the Department's professional medical staff that prior authorization is not warranted for a specific device or drug. When such prior authorization has been denied for a specific device or drug, the decision may be appealed as allowed by 89 Ill. Adm. Code 102.80(a)(7) and in accordance with the provisions for assistance appeals at 89 Ill. Adm. Code 104.
 - C) The amount of additional payment for devices or drugs, as described in subsection (b)(2)(A) of this Section, will be based on

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

the following methodology:

- i) The product of a cost to charge ratio that, in the case of cost reporting hospitals as described in Section 148.130(d), or in the case of other non-cost reporting providers, equals 0.5 multiplied by the provider's total covered charges on the qualifying claim, less the APL payment rate multiplied by four;
 - ii) If the result of subsection (b)(2)(C)(i) of this Section is less than or equal to zero, no additional payment will be made. If the result is greater than zero, the additional payment will equal the result of subsection (b)(2)(C)(i) of this Section, multiplied by 80 percent. In such cases, the provider will receive the sum of the APL payment and the additional payment for such high cost devices or drugs.
- D) For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amounts described in subsection (b)(1) of this Section multiplied by a factor of 2.72, ~~except that physical rehabilitation services provided by a general care hospital not enrolled with the Department to provide outpatient physical rehabilitation services shall be reimbursed at a rate of \$230.00 and the reimbursement rate for Type B psychiatric clinic services shall be \$224.00.~~
- E) Reimbursement rates for hospitals not required to file an annual cost report with the Department may be lower than those listed in this Section.
- F) Reimbursement for each APL group described in this subsection (b) shall be all-inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital; ~~and~~ chemotherapy services provided in conjunction with radiation

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

therapy services; ~~and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection (b)(1)(F) of this Section.~~ For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

- 3) The assignment of procedure codes to each of the reimbursement groups in subsection (b)(1) of this Section are detailed in the Department's Hospital Handbook and in notices to providers.
- 4) A one-time fiscal year 2000 payment will be made to hospitals. Payment will be based upon the services, specified in this Section, provided on or after July 1, 1998, and before July 1, 1999, which were submitted to the Department and determined eligible for payment (adjudicated) by the Department on or prior to April 30, 2000, excluding services for Medicare/Medicaid crossover claims and claims that resulted in a zero payment by the Department. A one-time amount of:
 - A) \$27.75 will be paid for each service for procedure code W7183 (Psychiatric clinic Type A for adults).
 - B) \$24.00 will be paid for each service for APL Group 5 (Psychiatric clinic Type A only) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
 - C) \$15.00 will be paid for each service for APL Group 6 (Physical rehabilitation services) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
- 5) County Facility Outpatient Adjustment
 - A) Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois county with a population of over three million shall be eligible for a county facility outpatient

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Section and are calculated as follows:

- i) Beginning with July 1, 1995, hospitals under this subsection shall receive an annual adjustment payment equal to total base year hospital outpatient costs trended forward to the rate year minus total estimated rate year hospital outpatient payments, multiplied by the resulting ratio derived when the value 200 is divided by the quotient of the difference between total base year hospital outpatient costs trended forward to the rate year and total estimated rate year hospital outpatient payments divided by one million.
 - ii) The payment calculated under this subsection (b)(5)(A) may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.
 - iii) The county facility outpatient adjustment under this subsection shall be made on a quarterly basis.
- B) County Facility Outpatient Adjustment Definition. The definitions of terms used with reference to calculation of the county facility outpatient adjustment are as follows:
- i) "Base Year" means the most recently completed State fiscal year.
 - ii) "Rate Year" means the State fiscal year during which the county facility adjustment payments are made.
 - iii) "Total Estimated Rate Year Hospital Outpatient Payments" means the Department's total estimated outpatient date of service liability, projected for the upcoming rate year.
 - iv) "Total Hospital Outpatient Costs" means the statewide sum of all hospital outpatient costs derived by summing each hospital's outpatient charges derived from actual paid

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

claims data multiplied by the hospital's cost-to-charge ratio.

- 6) Critical Access Hospital Rate Adjustment
Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485.subpart F shall be eligible for an outpatient rate adjustment for services identified in subsections (b)(1)(A) through (b)(1)(~~E~~)(~~F~~), excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:
- A) An annual distribution factor shall be calculated as follows:
 - i) The numerator shall be \$33 million.
 - ii) The denominator shall be the RY 2011 total outpatient cost coverage deficit calculated in accordance with 89 Ill. Adm. Code 148.115, less the RY 2011 Rural Adjustment Outpatient Payments calculated in accordance with 89 Ill. Adm. Code 148.115, plus the annual outpatient supplemental payment calculated in accordance with 89 Ill. Adm. Code 148.456.
 - B) Hospital Specific Adjustment Value
For each hospital qualified under this subsection (b)(6) the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in subsection (b)(6)(A)(ii) and the distribution factor calculated in subsection (b)(6)(A):
 - C) Final APL Rate Adjustment Values shall be the quotient of:
 - i) The hospital specific adjustment value identified in subsection (b)(6)(B) divided by
 - ii) The total outpatient services identified in subsections (b)(1)(A) through (b)(1)(F), excluding services for Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the Department's paid claims database as of December 31, 2010.
 - D) Non-State Government Owned Provider Adjustment

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

Final APL rates for hospitals identified in non-State government owned or operated providers in the State's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.304.

- E) **Applicability**
The rates calculated in accordance with subsection (b)(6)(A) shall be effective for dates of service beginning January 1, 2011 and shall be adjusted each State fiscal year beginning July 1, 2011.
- i) For State fiscal year 2011, the rate year shall begin January 1, 2011 and end June 30, 2011.
 - ii) For State fiscal year 2012 and beyond, the rate year shall be for dates of services beginning July 1 through June 30 of the subsequent year.
 - iii) For purposes of this adjustment, a children's hospital identified in Section 149.50(c)(3)(B) shall be combined with the corresponding general acute care parent hospital.
 - iv) Beginning with State fiscal year 2012 and each subsequent State fiscal year thereafter, the adjustment to the FY 2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5.
- 7) **No Year-End Reconciliation**
With the exception of the retrospective rate adjustment described in subsection (b)(9) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).
- 8) **Rate Adjustments**
With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(5) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
- A) The reimbursement rates described in subsection (b)(5) of this Section shall be no less than the reimbursement rates in effect on

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 9) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- 10) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- c) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:
 - 1) For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.
 - 2) For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2163 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).
 - 3) Payment for non-routine services. For services that are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3) but are not defined as a routine service under 42 CFR 405.2163

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

(1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.

- 4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.
 - 5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
 - A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
 - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
 - 6) With the exception of the retrospective rate adjustment described in subsection (c)(5) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).
 - 7) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) of this Section shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- d) Non Hospital-Based Clinic Reimbursement
- 1) County-Operated Outpatient Facility Reimbursement
Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as either a Maternal and Child Health Program managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), or as a Critical Clinic Provider, as described in subsection (e) of this Section, shall be on an all-inclusive

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

per encounter rate basis as follows:

- A) Base Rate. The per encounter base rate shall be calculated as follows:
 - i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.
 - ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.
 - iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section to determine the per encounter base rate.
 - iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) of this Section, shall be the per encounter base rate.

- B) Supplemental Rate
 - i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.
 - ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.
 - iii) The quotient derived in subsection (d)(1)(B)(i) of this Section shall be added to the product derived in subsection (d)(1)(B)(ii) of this Section, to determine the per encounter supplemental rate.
 - iv) The resulting sum, as described in subsection (d)(1)(B)(iii) of this Section, shall be the per encounter supplemental rate.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

C) Final Rate

- i) The per encounter base rate, as described in subsection (d)(1)(A)(iv) of this Section, shall be added to the per encounter supplemental rate, as described in subsection (d)(1)(B)(iv) of this Section, to determine the per encounter final rate.
- ii) The resulting sum, as determined in subsection (d)(1)(C)(i) of this Section, shall be the per encounter final rate.
- iii) The per encounter final rate, as described in subsection (d)(1)(C)(ii) of this Section, shall be adjusted in accordance with subsection (d)(2) of this Section.

2) Rate Adjustments

Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) of this Section, shall be calculated as follows:

- A) The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) and (e)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- C) The final rate described in subsection (d)(1)(C) of this Section shall be no less than \$147.09 per encounter.

3) County-operated outpatient facilities, as described in Section

148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

subsection (d).

- 4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- e) Critical Clinic Providers
- 1) Effective for services provided on or after September 27, 1997, a clinic owned or operated by a county with a population of over three million, that is within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection (e) require that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:
 - A) 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,
 - B) 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,
 - C) 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,
 - D) 3600 for reimbursement provided during the facility's cost reporting year ending during 2001, and
 - E) 4200 for reimbursement provided during the facility's cost reporting year ending during 2002.
 - 2) Reimbursement for all services provided by any Critical Clinic Provider shall be on an all-inclusive per-encounter rate that shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.

- 3) Critical Clinic Providers, as described in this subsection (e), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (e).
- 4) The reimbursement rates described in this subsection (e) shall be no less than the reimbursement rates in effect on July 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- f) Critical Clinic Provider Pharmacies
Prescribed drugs, dispensed by a pharmacy that is a Critical Clinic Provider, that are not part of an encounter reimbursable under subsection (e) of this Section shall be reimbursed at the rate described in subsection (e)(2) of this Section.

(Source: Emergency amended at 36 Ill. Reg. _____, effective July 1, 2012, for a maximum for 365 days)

Section 148.190 Copayments

EMERGENCY

Formatted: Font: Bold

- a) With the exception of those classes of individuals identified in 89 Ill. Adm. Code 140.402(d), copayments will be assessed on inpatient services provided under all Medical Assistance Programs administered by the Department. Copayments will be in the following amounts:
 - 1) Inpatient hospital services ~~in hospitals with an alternate cost per diem rate (see Section 148.270(a)) of \$325 or more \$3 per day, a daily co-payment amount as defined in federal regulations at 42 CFR 447.50 et seq., which for federal fiscal year 2012 is \$3.65.~~

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- ~~2) Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section 148.270(a)) of more than \$275 but less than \$325 \$2 per day.~~
- ~~3) Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section 148.270(a)) of \$275 or less No Copayment.~~
- 2) Non-emergency services defined as Emergency Level II and Non-emergency/Screening Level in 148.140 (b) rendered in an emergency room may require a nominal copayment amount as defined in federal regulations at 42 CFR 447.50 et seq., which for federal fiscal year 2012 is \$3.65. Individuals identified in 89 Ill. Adm. Code 140.402 (d)(1) and (d)(2) are subject to this copayment.

- b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the amount of the required copayment.
- c) No provider may deny care or services on account of an individual's inability to pay a copayment; this requirement, however, shall not extinguish the liability for payment of the copayment by the individual to whom the care or services were furnished.

(Source: Emergency amended at 36 Ill. Reg. ____ effective July 1, 2012, for a maximum of 365 days)

Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements

EMERGENCY

- a) Utilization Review
The Department, or its designated peer review organization, shall conduct utilization review in compliance with Section 1152 of the Social Security Act and 42 CFR Subchapter F (October 1, 2001). A peer review shall be conducted by a Physician Peer Reviewer who is licensed to practice medicine in all its branches, engaged in the active practice of medicine, board certified or board eligible in his or her specialty and has admitting privileges in one or more Illinois hospitals. Payment will only be made for those admissions and days approved by the Department or its designated peer review organization. Utilization review may consist of, but not be limited to, preadmission, concurrent, prepayment, and postpayment reviews to determine, pursuant to 42 CFR 476, Subpart C (October 1, 2001), the following:

Formatted: Font: Bold

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 1) Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;
 - 2) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges, including, but not limited to, the coordination of care requirements defined in Section 148.40(a)(10) for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program;
 - 3) Through DRG (Diagnosis Related Grouping) (see 89 Ill. Adm. Code 149) validation, the validity of diagnostic and procedural information supplied by the hospital;
 - 4) The completeness, adequacy and quality of hospital care provided;
 - 5) Whether the quality of the services meets professionally recognized standards of health care; or
 - 6) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type.
- b) Notice of Utilization Review
The Department shall provide hospitals with notice 30 days before a service is subject to utilization review, as described in subsections (c), (d), (e) and (f) of this Section, that the service is subject to such review. In determining whether a particular service is subject to utilization review, the Department may consider factors that include:
- 1) Assessment of appropriate level of care;
 - 2) The service could be furnished more economically on an outpatient basis;
 - 3) The inpatient hospital stays for the service deviate from the norm for inpatient stays using accepted length of stay criteria;
 - 4) The cost of care for the service;

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 5) Denial rates; and
 - 6) Trends or patterns that indicate potential for abuse.
- c) **Preadmission Review**
Preadmission review may be conducted prior to admission to a hospital to determine if the services are appropriate for an inpatient setting. The Department shall provide hospitals with notice of the criteria used to determine medical necessity in preadmission reviews 30 days before a service is subject to preadmission review.
- d) **Concurrent Review**
Concurrent review consists of a certification of admission and, if applicable, a continued stay review.
- 1) The certification of admission is performed to determine the medical necessity of the admission and to assign an initial length of stay based on the criteria for the admission. Admissions will be denied for patients age 21 years of age or over who present at a hospital within 60 days of a previous admission for specified alcohol-induced or drug-induced detoxification. The Department will specify to hospitals the lists of affected diagnosis codes via provider releases and postings on the Department's Web site.
 - 2) The continued stay review is conducted to determine the medical necessity and appropriateness of continuing the inpatient hospitalization. More than one continued stay review can be performed in an inpatient stay.
- e) **Prepayment Review**
The Department may require hospitals to submit claims to the Department for prepayment review and approval prior to rendering payment for services provided.
- f) **Postpayment Review**
Postpayment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct postpayment review on specific types of care.
- g) **Hospital Utilization Control**

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456 (October 1, 2001). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1) shall be in accordance with the federal regulations.

- h) Denial of Payment as a Result of Utilization Review
 - 1) If the Department determines, as a result of utilization review, that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:
 - A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission, transfer of an individual or failure to comply with the coordination of care requirements of Section 148.40.
 - B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.
 - 2) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization, under subsection (h)(1)(A) of this Section as a result of prepayment review, a reconsideration will be provided within 30 days upon the request of a hospital or physician if such request is the result of a medical necessity or appropriateness of care denial determination and is received within 60 days after receipt of the notice of denial. The date of the notice of denial is counted as day one.
 - 3) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization under

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

subsection (h)(1)(A) of this Section as a result of a preadmission or concurrent review, the hospital or physician may request an expedited reconsideration. The request for expedited reconsideration must include all the information, including the medical record, needed for the Department or its designated peer review organization to make its determination. A determination on an expedited reconsideration request shall be completed within one business day after the Department's or its designated peer review organization's receipt of the request. Failure of the hospital or physician to submit all needed information shall toll the time in which the reconsideration shall be completed. The results of the expedited reconsideration shall be communicated to the hospital by telephone within one business day and in writing within three business days after the determination.

- 4) A determination under subsection (h)(1) of this Section, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:
 - A) withholding Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
 - B) termination of the hospital's Provider Agreement.
- i) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements
 - 1) The applicable payments made under Sections 148.82, 148.120, 148.130, 148.150, 148.160, 148.170, 148.175 and 148.250 through 148.300 are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (i)(1)(B)(i) through (i)(1)(B)(v) of this Section .
 - A) Hospital-based physicians who may not bill separately on a fee-for-service basis:
 - i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.
- B) Hospital-based physicians who may bill separately on a fee-for-service basis:
 - i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.
 - ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.
 - iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.
 - iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.
 - v) A physician holding a nonteaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.
- 2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

- j) "Designated peer review organization" means an organization designated by the Department that is experienced in utilization review and quality assurance, which meets the guidelines in Section 1152 of the Social Security Act and 42 CFR 475 (October 1, 2001).

(Source: Emergency amended at 36 Ill. Reg. _____, effective July 1, 2012, for a maximum of 365 days)

Section 148.285 Excellence in Academic Medicine Payments (Repealed)

EMERGENCY

Formatted: Font: Bold

Formatted: Font: Bold

~~Payments for Qualified Academic Medical Center Hospitals providing graduate medical education shall be made for inpatient admissions occurring on or after July 1, 1996, and for Independent Academic Medical Center Hospitals providing graduate medical education shall be made for inpatient admissions occurring on or after July 1, 2001, as follows:~~

- a) ~~Subject to the availability of funds from the accounts within the Medical Research and Development Fund, including any federal financial participation reimbursed for payments under this subsection (a), payments shall be made to hospitals under the following criteria:~~
- ~~1) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive a percentage of the amount available from the National Institutes of Health Account, equal to that hospital's percentage of the total contracts and grants from the National Institutes of Health awarded to Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospitals and their affiliated medical schools during the preceding calendar year as reported to the Department.~~
 - ~~2) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Philanthropic Medical Research Account equal to 25 percent of all funded grants (other than grants funded by the State of Illinois or the National Institutes of Health) for biomedical research, technology, or programmatic development received by the Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital during the preceding calendar year as reported to~~

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

~~the Department.~~

- ~~3) Each Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital shall receive payment from the Market Medical Research Account equal to 20 percent of the funding for the project, if, based upon submission of information to the Department, the hospital:
 - ~~A) contributes 40 percent of the funding, that is at least \$100,000, for a biomedical research or technology project or a programmatic development project, and~~
 - ~~B) obtains contributions from the private sector equal to 40 percent of the funding for the project.~~~~

- ~~b) No hospital receiving payments from the Medical Research and Development Fund shall receive more than 20 percent of the total amount appropriated to the Fund, except that total payments from the Fund to the primary teaching hospitals affiliated with the Southern Illinois University School of Medicine in Springfield, considered as a single entity, may not exceed the product of:
 - ~~1) One sixth of the total amount available for distribution from the Medical Research and Development Fund, and~~
 - ~~2) The quotient of the National Institutes of Health grants or contracts awarded to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals in the previous calendar year divided by \$8,000,000.~~~~

- ~~e) The Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield, considered as a single entity, shall be deemed to be a Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital for the purposes of calculating subsections (a) and (b) of this Section. Payments under subsections (a) and (b) of this Section made to the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals located in Springfield shall be made to, and divided equally between, the primary teaching hospitals in Springfield.~~
- ~~d) Subject to the availability of funds from the Post-Tertiary Clinical Services Fund, including any federal financial participation reimbursed for payments under this subsection (d), payments shall be made to Qualified Academic Medical Center Hospitals for up to three Qualified Programs in any given year as reported to the~~

Formatted: Indent: Left: 1"

Formatted: Indent: Left: 1"

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

~~Department. Qualified Academic Medical Center Hospitals may receive continued funding for previously funded Qualified Programs rather than receive funding for a new program so long as the number of Qualified Programs receiving funding does not exceed three. Each hospital receiving payments under this subsection (d) shall receive an equal percentage of the Post Tertiary Clinical Services Fund to be used in the funding of Qualified Programs.~~

- e) ~~Subject to the availability of funds from the Independent Academic Medical Center Fund, including any federal financial participation reimbursed for payments under this subsection (c), payments shall be made to Independent Academic Medical Center Hospitals.~~
- f) ~~Payments from funds under this Section are made to cover the direct costs associated with providing Medicaid services and shall be made directly to the Qualified Academic Medical Center Hospitals or Independent Academic Medical Center Hospitals due the funds, except any funds due to any primary teaching hospital for the University of Illinois School of Medicine at Rockford and the University of Illinois School of Medicine at Peoria shall be paid to the University of Illinois at Chicago Medical Center, which shall be bound to expend the funds on its affiliated hospitals due the funds.~~
- g) ~~No Academic Medical Center Hospital shall be eligible for payments from the Medical Research and Development Fund unless the Academic Medical Center Hospital, in connection with its affiliated medical school, received at least \$8,000,000 in the preceding calendar year in grants or contracts from the National Institutes of Health, except that this restriction does not apply to the entity specified in subsection (c) of this Section.~~
- h) ~~The rate period for payments made under this Section shall be the 12 month period beginning July 1, 1996, for Qualified Academic Medical Center Hospitals, and July 1, 2001, for Independent Academic Medical Center Hospitals. A qualifying hospital's total annual payments from each fund and account described in this Section shall be divided into four equal payments and be made by the later of:~~
 - 1) ~~the fifteenth working day after July 1, October 1, January 1, and March 1, or~~
 - 2) ~~the fifteenth working day after the Department's receipt of reporting information required under subsection (j) of this Section.~~

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- i) ~~Payments made under this Section are for inpatient Medicaid services provided in the 12 month period preceding the rate period.~~
- j) ~~Qualified Academic Medical Center Hospitals initially identified by the Department as qualifying under any payment criteria of this Section must complete and return a survey, developed by the Department, attesting to information required to calculate payments under this Section. The Department will mail the survey at least 21 days prior to its due date. Failure to complete and submit required information by the due dates established by the Department will result in forfeiture of payments under this Section.~~
- k) ~~If a hospital is eligible for funds from the Independent Academic Medical Center Fund, that hospital shall not receive funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund. If a hospital receives funds from the Medical Research and Development Fund or the Post-Tertiary Clinical Services Fund, that hospital is ineligible to receive funds from the Independent Academic Medical Center Fund.~~
- l) ~~Definitions
As used in this Section, unless the context requires otherwise:~~
 - 1) ~~"Academic Medical Center Hospital" means a hospital located in Illinois which is either under common ownership with the college of medicine of a college or university, or a free-standing hospital in which the majority of the clinical chiefs of service are department chairmen in an affiliated medical school.~~
 - 2) ~~"Academic Medical Center Children's Hospital" means a children's hospital which is separately incorporated and non-integrated into the Academic Medical Center Hospital, but which is the pediatric partner for an Academic Medical Center Hospital and serves as the primary teaching hospital for pediatrics for its affiliated medical school. Children's hospitals which are separately incorporated, but integrated into the Academic Medical Center Hospital, are considered part of the Academic Medical Center Hospital.~~
 - 3) ~~"Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means an Academic Medical Center Hospital located in the Chicago Metropolitan Statistical Area.~~

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 4) ~~"Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means an Academic Medical Center Hospital located outside the Chicago Metropolitan Statistical Area.~~
- 5) ~~"Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means any Chicago Metropolitan Statistical Area Academic Medical Center Hospital that either directly or in connection with its affiliated medical school receives in excess of \$8,000,000 in grants or contracts from the National Institutes of Health during the calendar year preceding the beginning of the State fiscal year, except for the purposes of subsection (c) of this Section.~~
- 6) ~~"Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital" means the primary teaching hospital of the University of Illinois School of Medicine at Peoria, the primary teaching hospital for the University of Illinois School of Medicine at Rockford and the primary teaching hospitals for Southern Illinois University School of Medicine in Springfield.~~
- 7) ~~"Qualified Academic Medical Center Hospital" means a Qualified Chicago Metropolitan Statistical Area Academic Medical Center Hospital, a Qualified Non-Chicago Metropolitan Statistical Area Academic Medical Center Hospital or an Academic Medical Center Children's Hospital.~~
- 8) ~~"Independent Academic Medical Center Hospital" means the primary teaching hospital for the University of Illinois College of Medicine that is located in Urbana.~~
- 9) ~~"Qualified Program" includes:~~
 - A) ~~Thoracic transplantation: heart and lung, in particular;~~
 - B) ~~Cancer: particularly biologic modifiers of tumor response, and mechanisms of drug resistance in cancer therapy;~~
 - C) ~~Shock/Burn: development of biological alternatives to skin for grafting in burn injury, and research in mechanisms of shock and tissue injury in severe injury;~~
 - D) ~~Abdominal transplantation: kidney, liver, pancreas, and~~

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

~~development of islet cell and small bowel transplantation technologies;~~

~~E) Minimally invasive surgery: particularly laparoscopic surgery;~~

~~F) High performance medical computing: telemedicine and teleradiology;~~

~~G) Transmyocardial laser revascularization: a laser creates holes in heart muscles to allow new blood flow;~~

~~H) PET scanning: viewing how organs function (CT and MRI only allow viewing of the structure of an organ);~~

~~I) Strokes in the African-American community: particularly risk factors for cerebral vascular accident (strokes) in the African-American community at much higher risk than the general population;~~

~~J) Neurosurgery: particularly focusing on interventional neuroradiology;~~

~~K) Comprehensive eye center: including further development in pediatric eye trauma;~~

~~L) Cancers: particularly melanoma, head and neck;~~

~~M) Pediatric cancer;~~

~~N) Invasive pediatric cardiology;~~

~~O) Pediatric organ transplantation: transplantation of solid organs and marrow and other stem cells; and~~

~~P) Such other programs as may be identified by the Department and the Qualified Academic Medical Center Hospital, and approved by the Department, for those programs that meet appropriate biomedical research, technology, or programmatic development standards. Programs that meet appropriate biomedical research, technology or programmatic development standards are those~~

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

~~programs that help prevent, detect, diagnose, and treat disease and disability in humans by conducting research that seeks to produce new knowledge, developing or refining medical technologies, or creating, strengthening or expanding the clinical programs of academic medical centers. Moreover, such programs meet the purpose of the Excellence in Academic Medicine Act [30 ILCS 775/5]. That is, they stimulate excellence in academic medicine in Illinois for this and future generations, elevate Illinois as a national center for academic medicine and for health care innovation in the United States, and reverse the current health care trade imbalance so Illinois citizens may obtain highest quality post-tertiary care at home in Illinois.~~

(Source: Emergency repealed at 36 Ill. Reg. _____, effective July 1, 2012, for a maximum 365 days)

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

EMERGENCY

Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section. For a hospital that is located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 no new payment or rate increase that would otherwise become effective for dates of service on or after July 1, 2010 shall take effect under this Section unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in subsection (g)(5) of this Section no later than six months after the effective date of the first mandatory enrollment in the Coordinated Care Program.

- a) **Trauma Center Adjustments (TCA)**
The Department shall make a TCA to hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (DPH) in accordance with the provisions of subsections (a)(1) through (a)(4) of this Section. For the purpose of a TCA, a children's hospital, as defined under 89 Ill. Adm. Code 149.50(c)(3), operating under the same license as a hospital designated as a trauma center, shall be deemed to be a trauma center.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 1) Level I Trauma Center Adjustment.
 - A) Criteria. Hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by DPH shall receive the Level I trauma center adjustment. Hospitals qualifying under subsection (a)(2) are not eligible for payment under this subsection.
 - B) Adjustment. Hospitals meeting the criteria specified in subsection (a)(1)(A) of this Section shall receive an adjustment as follows:
 - i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$21,365 per Medicaid trauma admission in the CHAP base period.
 - ii) Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of \$14,165 per Medicaid trauma admission in the CHAP base period.

- 2) Level I Trauma Center Adjustment for hospitals located in the same city that alternate their Level I trauma center designation.
 - A) Criteria. Hospitals that are located in the same city and participate in an agreement in effect as of July 1, 2007, whereby their designation as a Level I trauma center by the Illinois Department of Public Health is rotated among qualifying hospitals from year to year or during a year, that are in the following classes:
 - i) A children's hospital – All children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3), in a given city, qualifying under subsection (a)(2)(A) shall be considered one entity for the purpose of calculating the adjustment in subsection (a)(2)(B).
 - ii) A general acute care hospital – All general acute care adult

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

hospitals, in a given city, affiliated with a children's hospital, as defined in subsection (a)(2)(A)(i), qualifying under subsection (a)(2)(A) shall be considered one entity for the purposes of calculating the adjustment in subsection (a)(2)(B).

- B) Adjustment. Hospitals meeting the criteria specified in subsection (a)(2)(A) shall receive an adjustment as follows:
 - i) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is equal to or greater than the mean Medicaid trauma admissions for the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of \$5,250 per Medicaid trauma admission for that class, in the CHAP base period.
 - ii) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is less than the mean Medicaid trauma admissions of the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of \$3,625 per Medicaid trauma admission for that class in the CHAP base period.
- 3) Level II Rural Trauma Center Adjustment. Rural hospitals, as defined in Section 148.25(g)(3), that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of \$11,565 per Medicaid trauma admission in the CHAP base period.
- 4) Level II Urban Trauma Center Adjustment. Urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of \$11,565 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:
 - A) The hospital is located in a county with no Level I trauma center; and

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(4) of this Section; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(4) of this Section; and
 - C) The hospital does not qualify under subsection (a)(2).
- 5) In determining annual payments that are pursuant to the Trauma Center Adjustments as described in this Section, for the CHAP rate period occurring in State fiscal year 2009, total payments will equal the methodologies described in this Section. For the period December 1, 2008 to June 30, 2009, payment will equal the State fiscal year 2009 amount less the amount the hospital received for the period July 1, 2008 to November 30, 2008.
- b) Rehabilitation Hospital Adjustment (RHA)
Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as free-standing acute comprehensive rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), and that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission (previously known as the Joint Committee on Accreditation of Healthcare Organizations), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following four components:
- 1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive \$4,215 per Medicaid Level I rehabilitation admission in the CHAP base period.
 - 2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:
 - A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

component of \$229,360 in the CHAP rate period.

- B) Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of \$527,528 in the CHAP rate period.
 - 3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) of this Section that are located in an HPSA on July 1, 1999, shall receive \$276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.
 - 4) Hospitals qualifying under this subsection (b) that are, as of July 1, 2010, designated as a "magnet hospital" by the American Nurses' Credentialing Center will receive a magnet component of \$1,500,000 annually for the period July 1, 2010 through ~~June 30, 2012~~ December 31, 2014.
- c) Direct Hospital Adjustment (DHA) Criteria
- 1) Qualifying Criteria
Hospitals may qualify for the DHA under this subsection (c) under the following categories unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006:
 - A) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:
 - i) were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999 and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;
 - ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999 and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(b)(1)(A), and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.
- B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999 and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.
- C) Children's hospitals, as defined under 89 Ill. Adm. Code 149.50(c)(3), on July 1, 1999.
- D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.
- E) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection (c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999 and provided more than 15,000 total days.
- F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999 and provided more than 7,500 total days and provided obstetrical care as of July 1, 2001.
- G) Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999 that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999 and provided 75 or

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

more Alzheimer days for patients diagnosed as having the disease.

- H) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(G) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.
 - I) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(H) of this Section, all other hospitals that had an MIUR greater than 23 percent on July 1, 1999, had an average length of stay less than four days, provided more than 4,200 total days and provided 100 or more Alzheimer days for patients diagnosed as having the disease.
 - J) A hospital that does not qualify under subsection (c)(1) of this Section because it does not operate a comprehensive emergency room will qualify if the hospital provider operates a standby emergency room, as defined in 77 Ill. Adm. Code 250.710(c), and functions as an overflow emergency room for its affiliate hospital provider, owned and controlled by the same governing body, that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), within one mile of the hospital provider.
- 2) DHA Rates
- A) For hospitals qualifying under subsection (c)(1)(A) of this Section, the DHA rates are as follows:
 - i) Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive \$69.00 per day for hospitals that do not provide obstetrical care and \$105.00 per day for hospitals that do provide obstetrical care.
 - ii) Hospitals that have a Combined MIUR that is equal to or

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive \$105.00 per day for hospitals that do not provide obstetrical care and \$142.00 per day for hospitals that do provide obstetrical care.

- iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive \$124.00 per day for hospitals that do not provide obstetrical care and \$160.00 per day for hospitals that do provide obstetrical care.
- iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive \$142.00 per day for hospitals that do not provide obstetrical care and \$179.00 per day for hospitals that do provide obstetrical care.

B) Hospitals qualifying under subsection (c)(1)(A) of this Section will also receive the following rates:

- i) County owned hospitals as defined in Section 148.25 with more than 30,000 total days will have their rate increased by \$455.00 per day.
- ii) Hospitals that are not county owned with more than 30,000 total days will have their rate increased by \$354.00 per day for dates of service on or after April 1, 2009.
- iii) Hospitals with more than 80,000 total days will have their rate increased by an additional \$423.00 per day.
- iv) Hospitals with more than 4,500 obstetrical days will have their rate increased by \$101.00 per day.
- v) Hospitals with more than 5,500 obstetrical days will have their rate increased by an additional \$194.00 per day.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- vi) Hospitals with an MIUR greater than 74 percent will have their rate increased by \$147.00 per day.
 - vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by \$385.00 per day through ~~December 31, 2014~~June 30, 2012. For dates of service on or after ~~January 1, 2015~~July 1, 2012, the rate is \$131.00.
 - viii) Hospitals with an MIUR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999 will have their rate increased by \$360.00 per day for dates of service on or after April 1, 2009.
 - ix) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than four days will have their rate increased by \$650.00 per day for dates of service on or after April 1, 2009.
 - x) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by \$320.50 per day.
 - xi) Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have an MIUR greater than 70 percent and have more than 20,000 days will have their rate increased by \$185.00 per day for dates of service on or after April 1, 2009.
 - xii) Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by \$148.00 per day.
- C) Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:
- i) Qualifying hospitals will receive a rate of \$421.00 per day.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- ii) Qualifying hospitals with more than 1,500 obstetrical days will have their rate increased by \$824.00 per day through ~~December 31, 2014~~~~June 30, 2012~~. For dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$369.00.
- D) Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:
- i) Hospitals will receive a rate of \$28.00 per day.
- ii) Hospitals located in Illinois and outside of HSA 6 that have an MIUR greater than 60 percent will have their rate increased by \$55.00 per day.
- iii) Hospitals located in Illinois and inside HSA 6 that have an MIUR greater than 80 percent will have their rate increased by \$573.00 per day. For dates of service on or after July 1, 2010 through ~~December 31, 2014~~~~June 30, 2012~~, this rate shall be increased by an additional \$47.00, to \$620.00.
- iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by:
- For hospitals that have fewer than 4,000 total days, \$32.00 per day.
 - For hospitals that have more than 4,000 total days but fewer than 8,000 total days, \$363.00 per day for dates of service through ~~December 1, 2014~~~~June 30, 2012~~; for dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$246.00 per day.
 - For hospitals that have more than 8,000 total days, \$295.00 per day for dates of service through ~~December 31, 2014~~~~June 30, 2012~~; for dates of service on or after ~~January 1, 2015~~~~July 1, 2012~~, the rate is \$178 per day.
- v) Hospitals with more than 3,200 total admissions will have

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

their rate increased by \$328.00 per day.

- E) Hospitals qualifying under subsection (c)(1)(D) of this Section will receive the following rates:
 - i) Hospitals will receive a rate of \$41.00 per day.
 - ii) Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional \$14.00 per day.
 - iii) Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional \$191.00 per day for dates of service on or after April 1, 2009.
 - iv) Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rate increased by an additional \$41.00 per day. For dates of service on or after July 1, 2010 through ~~June 30, 2012~~ December 21, 2014, this rate shall be further increased by \$54.00 per day, to \$95.00 per day.
- F) Hospitals qualifying under subsection (c)(1)(E) of this Section will receive \$188.00 per day.
- G) Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of \$55.00 per day.
- H) Hospitals that qualify under subsection (c)(1)(G) of this Section will receive the following rates:
 - i) Hospitals with an MIUR greater than 19.75 percent will receive a rate of \$69.00 per day.
 - ii) Hospitals with an MIUR equal to or less than 19.75 percent, will receive a rate of \$11.00 per day.
- I) Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of \$268.00 per day.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- J) Hospitals qualifying under subsection (c)(1)(I) of this Section will receive a rate of \$328.00 per day if federal approval is received by the Department for such a rate; otherwise, the rate shall be \$238.00 per day.
 - K) Hospitals that qualify under subsection (c)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two. The payments calculated under this Section to hospitals that qualify under subsection (c)(1)(A)(iii) of this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustments for hospitals qualifying under subsection (c)(1)(A)(iii) of this Section.
- 3) DHA Payments
- A) Payments under this subsection (c) will be made at least quarterly, beginning with the quarter ending December 31, 1999.
 - B) Payment rates will be multiplied by the total days.
 - C) For the CHAP rate period occurring in State fiscal year 2011, total payments will equal the methodologies described in subsection (c)(2) of this Section.
- d) Rural Critical Hospital Adjustment Payments (RCHAP)
RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive \$367,179 per year. The Department shall also make an RCHAP to hospitals qualifying under this subsection at a rate that is the greater of:
- 1) the product of \$1,367 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or
 - 2) the product of \$138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- e) **Total CHAP Adjustments**
Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in subsections (a), (b), (c) and (d) of this Section. The critical hospital adjustment payments shall be paid at least quarterly.
- f) **Critical Hospital Adjustment Limitations**
Hospitals that qualify for trauma center adjustments under subsection (a) of this Section shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in subsection (a)(1) of this Section, or a Level II trauma center as required for the adjustment described in subsection (a)(2) or (a)(3) of this Section. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased. This limitation does not apply to hospitals qualifying under subsection (a)(2). Payments under this Section are subject to federal approval.
- g) **Critical Hospital Adjustment Payment Definitions**
The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:
- 1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.
 - 2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995 CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996 CHAP rate period; etc.
 - 3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.
 - 4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120(k)(5), plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(k)(6), as of July 1, 1999.
 - 5) "Coordinated Care Participating Hospital" means a hospital that is located

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

in a countygeographic-area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 ILCS 5/5-30 that is one of the following:

- A) Has entered into a contract to provide hospital services to enrollees of the care coordination program.
 - B) Has not been offered a contract by a care coordination plan that pays not less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplement payment that the Department pays directly.
 - C) Is not licensed to serve the population mandated to enroll in the care coordination program.
- 6) "Medicaid general care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.
- 7) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.
- 8) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 9) "Medicaid obstetrical care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with Diagnosis Related Grouping (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.
- 10) "Medicaid trauma admission" means those claims billed as admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.
- 11) "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.
- 12) "RCHAP general care admissions" means Medicaid General Care Admissions, as defined in subsection (g)(4) of this Section, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.
- 13) "RCHAP obstetrical care admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection (g)(7) of this Section, with a Diagnosis Related Grouping (DRG) of 370 through 375, occurring in the CHAP base period.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 14) "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
- 15) "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
- 16) "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; V27 through V27.9; V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

(Source: Emergency amended at 36 Ill. Reg. _____, effective July 1, 2012, for a maximum of 365 days)

Section 148.458 General Provisions

Unless otherwise indicated, the following apply to Sections 148.440 through 148.456.

a) Definitions.

"Base inpatient payments" means, for a given hospital, the sum of payments made using the rates defined in Section 148(b)(1) for services provided during State fiscal year 2005 and adjudicated by the Department through March 23, 2007.

"Capital cost per diem" means, for a given hospital, the quotient of (i) the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by (ii) the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies hospital cost index. If a hospital's 2005 Medicare

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

cost report is not contained in the Healthcare Cost Report Information System, the Department shall use the data reported on the hospital's 2005 Medicaid cost report.

"Case mix index" means, for a given hospital, the quotient resulting from dividing (i) the sum of the all diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, by (ii) the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

"Children's hospital" means a hospital as described in Section 149.50(c)(3).

"Eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

"Freestanding children's hospital" means an Illinois Children's hospital that is licensed by the Illinois Department of Public Health as a pediatric hospital.

"Freestanding specialty hospital" means an Illinois hospital that is neither a general acute care hospital nor a large public hospital nor a freestanding children's hospital.

"General acute care hospital" means an Illinois hospital that operates under a general license (i.e., is not licensed by the Illinois Department of Public Health as a psychiatric, pediatric, rehabilitation, or tuberculosis specialty hospital) and is not a long term stay hospital, as described in Section 149.50(c)(4).

"Large public hospital" means a county-owned hospital, as described in Section 148.25(b)(1)(a), a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(b), or a hospital owned or operated by a State agency, as described in Section 148.40(a)(7).

"Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005 as adjudicated by the

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

Department through March 23, 2007.

"Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to Illinois recipients of medical assistance under Title XIX of the federal Social Security Act, assigned a diagnosis related group code of 370 through 375, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005, adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical rate" means, for a given hospital, a fraction, the numerator of which is the hospital's Medicaid obstetrical days and the denominator is the hospital's Medicaid inpatient days.

"Medicare crossover rate" means, for a given hospital, a fraction, the numerator of which is the number patient days provided to individuals eligible for both Medicare under Title XVIII and Medicaid under Title XIX of the federal Social Security Act and the denominator of which is the number patient days provided to individuals eligible for medical programs administered by the Department, both as recorded in the Department's paid claims data.

"MIUR" means Medicaid inpatient utilization rate as defined in Section 148.120(K)(4).

b) Payment.

1) The annual amount of each payment for which a hospital qualifies shall be made in 12 equal installments on or before the seventh State business day of each month. If a hospital closes or ceases to do business, payments will be prorated based on the number of days the hospital was open during the State fiscal year in which the hospital closed or ceased to do business.

2) Monthly payments may be combined into a single payment to a qualifying hospital. Such a payment will represent the total monthly payment a qualifying hospital receives pursuant to Sections 148.440 through 148.456.

3) [The Department may adjust payments made pursuant to Article V-A of the Public Aid Code to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.](#)

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

4) If the federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under Article V-A of the Illinois Public Aid Code is exceeded, then the payments under Article V-A of the Illinois Public Aid Code that exceed the applicable federal upper limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

c) Rate reviews.

- 1) A hospital shall be notified in writing of the results of the payment determination pursuant to Sections 148.440 through 148.456.
- 2) Hospitals shall have a right to appeal the calculation of, or their ineligibility for, payment if the hospital believes that the Department has made a technical error. The appeal must be submitted in writing to the Department and must be received or postmarked within 30 days after the date of the Department's notice to the hospital of its qualification for the payment amounts, or a letter of notification that the hospital does not qualify for payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

(Source: Emergency amendment at 36 Ill. Reg. _____, effective July 1, 2012, for a maximum of 365 days)

SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

Section 148.510 Reimbursement

EMERGENCY

When a hospital or ambulance provider furnishes emergency services, a hospital or health care professional or laboratory provides follow-up healthcare, or a pharmacy dispenses prescribed medications to any sexual assault survivor who is neither eligible to receive those services under the Illinois Public Aid Code [305 ILCS 5/5] nor covered for those services by a policy of insurance, the hospital, ambulance provider, health care professional, laboratory or pharmacy shall furnish the services without charge to that person, and shall be entitled to be reimbursed in providing the services, under the following conditions:

- a) An Illinois hospital shall be eligible for reimbursement only after receiving

Formatted: Font: Bold

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

Department of Public Health approval for participation as a Sexual Assault Treatment Facility or as a Sexual Assault Transfer Facility.

- b) Charges for outpatient emergency care, physician, and ambulance transportation, and other related charges, shall be reimbursed only through the hospital outpatient billing department.
- 1) Physicians, ambulance providers, and other miscellaneous medical providers rendering services in the hospital emergency department shall not be directly reimbursed by the Department of Healthcare and Family Services.
 - 2) Charges for inpatient care shall not be reimbursed.
 - 3) Charges must be directly related to care rendered for examinations, injuries, or trauma resulting from a sexual assault and/or the completion of sexual assault evidence collection through the use and application of the Illinois State Police Sexual Assault Evidence Collection Kit.
 - 4) Emergency services must have been provided within the hospital emergency department or under the direction of an attending emergency room physician at the facility who supervised or provided the hospital emergency care of the sexual assault survivor, or during the ambulance transport of the sexual assault survivor.
 - 5) Charges may include, but are not limited to, outpatient emergency care, physician, laboratory, x-ray, pharmacy and ambulance services, including charges for follow-up visits to the emergency department that are related to the sexual assault and occur within 90 days after the initial visit.
 - 6) ~~The billed charges for services~~ Services provided to sexual assault survivors shall be reimbursed at the Department's reimbursement rates, no greater than the provider's customary charges to the general public for those types of services. ~~Physician fees shall be no greater than those considered usual and customary in the community. Pharmacy services shall be reimbursed at the Department's pharmacy reimbursement rates established in 89 Ill. Adm. Code 140.445 and 89 Ill. Adm. Code 140.446.~~
 - 7) Claims must be received by the Department within 180 days ~~12 months~~ from the date of service to be eligible for payment pursuant to 89 Ill. Adm. Code 140.20.

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- c) The hospital shall maintain sufficient records to document its charges for services to each sexual assault survivor. The records shall be available for the Department's review upon its request and shall contain at least the following:
- 1) Sexual assault survivor's name, address, date of birth, Social Security Number, marital status, sex, employer and name of parent or guardian (if minor patient);
 - 2) Date of service;
 - 3) Hospital patient number and name of attending physician;
 - 4) List of services provided;
 - 5) Charges for each service;
 - 6) Any documentation concerning the sexual assault survivor's insurance coverage; and
 - 7) A report outlining each service provided and paid for by the Department and the services available to sexual assault survivors.
- d) The hospital outpatient-billing department shall submit the following documentation in order to be considered for reimbursement:
- ~~1)~~ ~~The Illinois Department of Healthcare and Family Services Sexual Assault Survivor Program Outpatient Hospital Billing Form, completed in its entirety for the initial visit and follow-up visits;~~
 - ~~12)~~ ~~When applicable, the Billing Form with Documentation~~documentation of any insurance payment that has been received, or a copy of the denial from the insurance carrier;
 - ~~23)~~ A legible copy of the emergency room admission form with physician's notes and orders and nurse's notes; and
 - ~~34)~~ ~~A Universal Billing (UB) Form and itemized~~itemized statement of all charges ~~from each provider.~~
- e) The health care professional who provides follow-up healthcare, the laboratory

ILLINOIS REGISTER

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

that furnishes follow-up services, and the pharmacy that dispenses related prescribed medications to a sexual assault survivor are responsible for submitting the request for reimbursement for follow-up healthcare, laboratory services or pharmacy services to the Illinois Sexual Assault Emergency Treatment Program under the Department of Healthcare and Family Services. Health care professionals, ~~and~~ laboratories and pharmacies are ~~entitled~~ to be reimbursed at the Department's reimbursement rates for their billed charges. Pharmacies shall be reimbursed at the Department's pharmacy reimbursement rates established in 89 Ill. Adm. Code 140.445 and 140.446.

- f) Under no circumstances shall a sexual assault survivor be billed for outpatient hospital care, emergency room care, follow-up health care or transportation services when the services are directly related to the sexual assault.
- g) A request for reimbursement that is rejected by the Department shall be returned to the requestor and accompanied by an explanation that specifies the basis for rejection. Corrected or amended requests may be resubmitted to the Department within 180 days ~~12 months~~ from the date of service pursuant to 89 Ill. Adm. Code 140.20.

(Source: Emergency amended at 36 Ill. Reg. _____, effective July 1, 2012, for a maximum 365 days)