

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.126 Safety Net Adjustment Payments

- 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).
 - 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:~~
- ~~A) Does not already qualify under subsections (a)(1) through (a)(7) of this Section.~~
 - ~~B) Is located outside of HSA-6.~~
 - ~~C) Has an MIUR greater than 16 percent.~~
 - ~~D) Has more than 475 licensed beds.~~
 - ~~E) Has an average length of stay less than five days.~~
- 8)9) 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)10) 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).

- 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 two 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.
 - 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 CMIUR greater than 25 percent.
 - C) Has an MIUR greater than 12 percent.
 - D) Is designated a perinatal level two 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.
- b) The following five classes of hospitals are ineligible for safety net adjustment payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4) and subsections (a)(6) through (a)(9) 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~~ \$200.50.
 - 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.
 - 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"- \$125.00.
 - H) A children's hospital that is a rural hospital-\$145.00.
 - I) 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.
- 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-\$70.00.
 - ii) Does not provide obstetrical care-\$30.00.
 - iii) Is a trauma center, recognized by the Illinois Department of Public Health (IDPH), as of July 1, 2005-\$173.50 ~~\$84.00~~.
- K) A qualifying hospital that provided greater than 35,000 total days in the safety net hospital base year-\$6.00.
- 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-\$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 \$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 \$53.00.
- 7) For a hospital qualifying under subsection (a)(7) of this Section, the rate is \$175.50 ~~\$117.00~~.

- 8) ~~For a hospital qualifying under subsection (a)(8) of this Section, the rate is \$34.50.~~
- 8)9) For a hospital qualifying under subsection (a)(~~8~~)(9) of this Section, the rate is \$124.50.
- 9)10) For a hospital qualifying under subsection (a)(~~9~~)(10) of this Section, the rate is \$85.50.
- 10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is \$13.75.
- 11) For a hospital qualifying under subsection (a)(11) of this Section, the rate is \$39.50.
- 12) For a hospital qualifying under subsection (a)(12) of this Section, the rate is \$120.25.
- 13) For a hospital qualifying under subsection (a)(13) of this Section, the rate is \$231.50.
- 14) For a hospital qualifying under subsection (a)(14) of this Section, the rate is \$172.00.

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 2006, total payments will equal the methodologies described in subsection (c) of this Section. For the period October 1, 2005 through June 30, 2006, payment will equal the State fiscal year 2006 amount less the amount the hospital received under the safety net adjustment period for the quarter ending September 30, 2005.
- 3) For safety net adjustment periods occurring after State fiscal year 2006, total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital during the safety net adjustment period 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(k)(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).
- 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(k)(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 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.
- 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.

(Source: Amended at 30 Ill. Reg. _____, effective _____)

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

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.

- a) **Trauma Center Adjustments (TCA)**
The Department shall make a TCA to Illinois 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 (IDPH) in accordance with the provisions of subsections (a)(1) through (a)(3) of this Section.
 - 1) **Level I Trauma Center Adjustment.**
 - A) **Criteria.** Illinois hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by the Illinois Department of Public Health shall receive the Level I trauma center adjustment.
 - B) **Adjustment.** Illinois 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 \$21,365.00 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 \$14,165.00 per Medicaid trauma admission in the CHAP base period.
 - 2) **Level II Rural Trauma Center Adjustment.** Illinois 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 \$11,565.00 per Medicaid trauma admission in the CHAP base period.
 - 3) **Level II Urban Trauma Center Adjustment.** Illinois 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 \$11,565.00 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
 - 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)(3) 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)(3) of this Section.
- b) **Rehabilitation Hospital Adjustment (RHA)**
Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as 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), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:
- 1) **Treatment Component.** All hospitals defined in subsection (b) of this Section shall receive \$4,215.00 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 component of \$229,360.00 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 \$527,528.00 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.

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
 - 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 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.

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 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 \$330.00 per day.
- 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.
- 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 \$41.00 per day.
- 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 \$227.00 per day.
- 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 ~~\$528.00~~ \$182.25 per day.
- 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~~ \$281.00 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 \$98.00 per day.

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.
- ii) Qualifying hospitals with more than 1,500 Obstetrical days will have their rate increased by \$369.00 per day.

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.
- iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by \$32.00 per day for hospitals that have fewer than 4,000 Total days; or \$246.00 per day for hospitals that have more than 4,000 Total days but fewer than 8,000 Total days; or \$178.00 per day for hospitals that have more than 8,000 Total days.
- v) Hospitals with more than 3,200 Total admissions will have 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 ~~\$87.00~~ \$110.25 per day.
 - 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.
- 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.
- J) Hospitals qualifying under subsection (c)(1)(I) of this Section will receive a rate of \$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) Total Payment Adjustments
 - i) For the CHAP rate period occurring in State fiscal year 2006, total payments will equal the methodologies described in subsection (c)(2) of this Section. For the period January 1, 2006, to June 30, 2006, payment will equal the State fiscal year 2006 amount less the amount the hospital received under DHA for the quarters ending September 30, 2006, and December 31, 2006.
 - ii) For CHAP rate periods occurring after State fiscal year 2006, 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 \$367,179.00 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 \$1,367.00 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.
- 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.

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) "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.
- 6) "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.

- 7) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.
- 8) "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.
- 9) "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.
- 10) "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.

- 11) "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.
- 12) "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.
- 13) "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.
- 14) "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.
- 15) "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: Amended at 30 Ill. Reg. _____, effective _____)