

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.140 Hospital Outpatient and Clinic Services

- a) Fee-For-Service Reimbursement
 - 1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:
 - 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) which 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.
- 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, 2004~~, 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

- 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 procedure shall be \$1,794.00 ~~\$1,709.00~~.
- 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 procedure shall be \$1,049.00 ~~\$999.00~~.
- 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 procedure shall be \$752.00 ~~\$716.00~~.
- 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. The rate for this procedure shall be \$287.00 ~~\$273.00~~.

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 procedure shall be \$941.00 ~~\$896.00~~.

- 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 shall be \$304.00 ~~\$290.00~~.
 - 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 shall be \$176.00 ~~\$168.00~~.
 - 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 shall be \$136.00 ~~\$130.00~~.
- 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 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 ~~\$172.00~~.

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 ~~\$64.00~~.

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 ~~\$25.00~~.

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:

i) for at least 60 minutes but less than six hours and 31 minutes of services, the rate shall be \$74.00 ~~\$70.00~~;

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 ~~\$211.00~~; or

iii) for at least 12 hours and 31 minutes or more of services, the rate shall be \$443.00 ~~\$422.00~~.

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).

- 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 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 ~~2.856~~, 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 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 which 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 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 claims data multiplied by the hospital's cost-to-charge ratio.

6) No Year-End Reconciliation

With the exception of the retrospective rate adjustment described in subsection (b)(8) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).

7) 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 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.

- 8) 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) which 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.
 - 9) 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 which 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 which 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 (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 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.

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 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) which 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 which shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting 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: Amended at 29 Ill. Reg. _____, effective _____)