**Section 148.120 Disproportionate Share Hospital (DSH) Adjustments**

Effective for dates of service on or after July 1, 2014:

a) Qualified Disproportionate Share Hospitals (DSH). The Department shall make adjustment payments to hospitals that are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in subsection (i)(4), is at least one standard deviation above the mean Medicaid utilization rate, as defined in subsection (i)(3).

2) The hospital's low income utilization rate, as defined in subsection (i)(6), exceeds 25 per centum.

b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform nonemergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in Section 148.25(d), must submit a statement to that effect.

c) In making the determination described in subsection (a)(1), the Department shall utilize:

1) Hospital Cost Reports

A) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (i)(4), that have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.

B) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsection (a)(1). Submittal of a corrected cost report in support of subsection (a)(1) must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's MIUR as described in subsection (i)(4).

C) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (i)(4), that have been derived from unaudited cost reports are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.  Pursuant to subsection (c)(1)(B), hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination.

D) In the event a subsequent final audited cost report reflects an MIUR, as described in subsection (i)(4), that is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the MIUR based upon the final audited cost report, and recoup any overpayments made if the percentage change in the DSH payment rate is greater than five percent.

2) Days Not Available from Cost Report

Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid managed care entity (MCE) days, hospital residing long term care days, and Medicaid days for alcohol and substance abuse sub-acute care under category of service 035. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year.

B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

C) MCE days. The Department will utilize the Department's MCE claims data available to the Department as of the last day of June preceding the DSH determination year, or specific claim information from each MCE, for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an MCE.

D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.

E) Alcohol and Substance Abuse Days. The Department will utilize its paid claims data under category of service 35 available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided for alcohol and substance abuse rehabilitative care.

d) Hospitals may apply for DSH status under subsection (a)(2) by submitting an audited certified financial statement, for the hospital's base fiscal year, to the Department. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:

1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discount), for the hospital's base fiscal year.

4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the state in which they are located based upon the federal definition of a DSH hospital (42 USC 1396-4(b)(1)) may qualify for DSH hospital adjustments under this Section. For purposes of determining the MIUR, as described in subsection (i)(4) and as required in the federal definition (42 USC 1396r-4(b)(1)), out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the MIUR from their state may submit an audited certified financial statement as described in subsection (d). Payments to out-of-state hospitals will be allocated using the same method as described in subsection (g).

f) Time Limitation Requirements for Additional Information.

1) The information required in subsections (a), (c), (d) and (e) must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of the information for the determination of DSH qualification. Information required in subsections (a), (c), (d) and (e) that is not received or post marked in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

2) The information required in subsection (b) must be submitted after receipt of notification from the Department. Information required in this Section that is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

g) Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by subsection (a) shall be calculated annually as follows:

1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1), with the exception of any Illinois hospital that is owned or operated by the State or a unit of local government.

A) Hospitals qualifying as DSH hospitals under subsection (a)(1) or (a)(2) will receive an add-on payment to their inpatient rate.

B) The distribution method for the add-on payment described in subsection (g)(1) is based upon a fund of $5 million. All hospitals qualifying under subsection (g)(1)(A) will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) in proportion to the percentage by which the hospital's MIUR exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate, as described in subsection (i)(3). This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the $5 per day base add-on has been subtracted.

D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C), plus the initial $5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B), is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day add-on value. Hospitals qualifying under subsection (a)(2) will receive the minimum adjustment of $5 per inpatient day. The adjustments calculated under this subsection (g)(1) are subject to the limitations described in subsection (h). The adjustments calculated under subsection (g) shall be paid on a per diem basis and shall be applied to each covered day of care provided.

2) Department of Human Services (DHS) State-Operated Facility Adjustment for Hospitals Defined in Section 148.25(a)(3). DHS State-operated facilities qualifying under subsection (a)(2) shall receive an adjustment calculated as follows:

A) The amount of the adjustment is based on a State DSH Pool. The State DSH Pool amount shall be the federal DSH allotment for mental health facilities as determined in section 1923(h) of the Social Security Act, minus the estimated DSH payments to such facilities that are not operated by the State.

B) The State DSH Pool amount is then allocated to hospitals defined in Section 148.25(a)(3) that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uncompensated care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uncompensated care costs.

C) The adjustment calculated in subsection (g)(2)(B) shall meet the limitation described in subsection (h)(4).

D) The adjustment calculated pursuant to subsection (g)(2)(B), for each hospital defined in Section 148.25(a)(3) that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in subsection (h). The adjustment described in this subsection (g)(2)(D) shall be paid on a quarterly basis.

3) Assistance for Certain Public Hospitals

A) The Department may make an annual payment adjustment to qualifying hospitals in the DSH determination year. A qualifying hospital is a public hospital as defined in section 701(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554).

B) Hospitals qualifying shall receive an annual payment adjustment that is equal to:

i) A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, section 701(d)(3)(B) for the DSH determination year;

ii) Divided first by Illinois' Federal Medical Assistance Percentage;

iii) Divided secondly by the sum of the qualified hospitals' total Medicaid inpatient days, as defined in subsection (i)(4); and

iv) Multiplied by each qualified hospital's Medicaid inpatient days as defined in subsection (i)(4).

C) The annual payment adjustment calculated under this subsection (g)(3), for each qualified hospital, will be divided by four and paid on a quarterly basis.

D) Payment adjustments under this subsection (g)(3) shall be made without regard to subsections (h)(3) and (4) of this Section, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

E) In order to qualify for assistance payments under this subsection (g)(3), with regard to this payment adjustment, there must be in force an executed intergovernmental agreement between the authorized governmental body of the qualifying hospital and the Department.

4) Disproportionate Share Payments for Certain Government-Owned

or -Operated Hospitals

A) The following classes of government-owned or -operated Illinois hospitals shall, subject to the limitations set forth in subsection (h), be eligible for the Disproportionate Share Hospital Adjustment payment:

i) Hospitals defined in Section 148.25(a).

ii) Hospitals owned or operated by a unit of local government that is located within Illinois and is not a hospital defined in subsection (i).

B) The annual amount of the payment shall be the amount computed for the hospital pursuant to federal limitations.

C) The annual amount shall be paid to the hospital in monthly installments.

h) DSH Adjustment Limitations

1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues provision of nonemergency obstetrical care. The provisions of this subsection (h)(1) shall not apply to those hospitals described in Section 148.25(d) or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987. In this instance, the adjustments calculated under subsection (g)(1) shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.

2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for DSH payment adjustments based upon the requirements of this Section.

3) DSH Payment Adjustment. If the aggregate DSH payment adjustments calculated under this Section do not meet the State's final DSH Allotment as determined by the federal Centers for Medicare and Medicaid Services, DSH payment adjustments calculated under this Section shall be adjusted to meet the State DSH Allotment. Subject to any limitation, disproportionate share payments will be made to qualifying hospitals in the following order:

A) Hospitals defined in Section 148.25(a)(3) – the annual amount shall be credited quarterly via certification of public expenditure.

B) Hospitals defined in Section 148.25(a)(2).

C) Hospitals defined in subsection (g)(4)(A)(ii) of this Section.

D) Hospitals that are not owned or operated by a unit of government – the annual amount shall be paid on each inpatient claim.

E) Hospitals defined in Section 148.25(a)(1).

4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of estimated Medicaid payments (inpatient, outpatient, and disproportionate share) to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. Federal upper payment limit requirements (42 CFR 447.272) shall be considered when calculating the OBRA'93 adjustments. The adjustments shall reduce disproportionate share spending until the costs and spending (described in this subsection (h)(4)) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.

5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's MIUR, as defined in subsection (i)(4) of this Section, is less than one percent.

i) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

1) "Base fiscal year" means the hospital's fiscal year ending in the calendar year 22 months before the beginning of the DSH determination year.

2) "DSH determination year" means the 12-month period beginning on October 1 of the year and ending September 30 of the following year.

3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. In this subsection (i)(3), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

4) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12 month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a et seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. In this subsection (i)(4), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

5) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

6) "Low income utilization rate" means a fraction, expressed as a percentage that is the sum of the amount resulting from the calculations in subsection (i)(6)(A) plus (i)(6)(B):

A) The fraction (expressed as a percentage) −

i) the numerator of which is the sum of the total revenues paid the hospital for patient services under Medicaid State plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and the amount of the cash subsidies for patient services received directly from State and local governments, and

ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

B) The fraction (expressed as a percentage) −

i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in subsection (6)(A)(i); and

ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)