**Section 148.160 Payment Methodology for County-Owned Large Public Hospitals**

a) Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on July 1, 2014 through December 31, 2015:

1) Inpatient Reimbursement Methodology

In accordance with 89 Ill. Adm. Code 149.50(b)(5), county-owned hospitals, as defined in Section 148.25(a)(1), are excluded from the DRG PPS for reimbursement for inpatient hospital services and are reimbursed on a per diem basis.

A) Inpatient Per Diem Rate Calculation

County-owned hospital inpatient per diem rates are calculated as follows:

i) Each county-owned hospital's inpatient base year costs, including operating capital and direct medical education costs, shall be calculated using inpatient base period claims data and Medicare cost report data with reporting periods matching the inpatient base period. Effective July 1, 2018, direct and indirect medical education costs shall be reduced from the inpatient base year cost.

ii) The inpatient base year costs shall be inflated from the midpoint of the inpatient base period claims data to the midpoint of the time period for which rates are being set (rate period) based on an inflation methodology determined by the Department and approved by Centers for Medicare and Medicaid Services (CMMS).

iii) Calculate the sum of:

• The total hospital inflated base year costs, excluding non-Medicare crossover claims, in the inpatient base period claims data; and

• Total uncovered Medicare crossover claim cost in the inpatient base period claims data.

iv) The inpatient per diem rate shall be the quotient of:

• Combined inflated base year cost and uncovered Medicare crossover claims cost, per subsection (a)(1)(C); and

• Total hospital base year covered days, excluding non-Medicare crossover claims, in the inpatient base period claims data.

v) The inpatient per diem rates shall be reduced if resulting payments exceed available Department funding or the CMMS Upper Payment Limit.

B) Rate Updates

County-owned hospital per diem rates shall be updated on an annual basis using more recent inpatient base period claims data, Medicare cost report data and cost inflation data.

C) New hospitals, for which inpatient base period claims data or Medicare cost reports are not on file, will be reimbursed the per diem rate calculated in subsection (a)(1)(A).

D) Review Procedure

The review procedure shall be in accordance with Section 148.310.

2) Outpatient Reimbursement Methodology

Large public hospitals, as defined in Section 148.25(a), are included in the EAPG PPS for reimbursement for outpatient hospital services as described in Section 148.140, and are to receive provider-specific EAPG standardized amounts.

A) Outpatient EAPG Standardized Amount Calculation

County-owned hospital outpatient EAPG standardized amounts are calculated as follows:

i) Each county-owned hospital's outpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using outpatient base period claims data and Medicare cost report data with reporting periods matching the outpatient base period.

ii) The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMMS.

iii) Prior to July 1, 2018, EAPG standardized amounts shall be determined for each county-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data. Effective July 1, 2018, EAPG standardized amounts shall be determined for each county-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period claims data, less an amount calculated in Section 148.406(f).

iv) EAPG standardized amounts shall be reduced if resulting payments exceed available HFS funding or the CMMS Upper Payment Limit.

B) Rate Updates and Adjustments

i) County-owned hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data, and costs inflation data.

ii) Restructuring Adjustments

Adjustments to outpatient base year costs, as described in subsection (a)(2)(A), will be made to reflect restructuring since filing the base year costs reports. The restructuring must have been mandated to meet State, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR 405, Subpart D, (1982)) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring cost must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available cost reports to determine restructuring costs.

C) New hospitals, for which outpatient base period claims data or Medicare cost reports are not on file, will be reimbursed the EAPG standardized amount calculated in subsection (a)(2)(A).

D) Review Procedure

The review procedure shall be in accordance with Section 148.320.

3) Definitions, as used in this Section:

"Inpatient base period paid claims data" means:

Prior to July 1, 2018, Medicaid fee-for-service inpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period.

Effective July 1, 2018, Medicaid fee-for-service and MCO encounter inpatient claims data from the State fiscal year ending 12 months prior to the beginning of the rate period.

"Outpatient base period paid claims data" means:

Prior to July 1, 2018, Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 36 months prior to the beginning of the rate period, excluding crossover claims.

Effective July 1, 2018, Medicaid fee-for-service and MCO encounter outpatient claims data from the State fiscal year ending 12 months prior to the beginning of the rate period, excluding crossover claims.

"Rate period" means the State fiscal year for which the county-owned hospital inpatient and outpatient rates are effective.

b) Effective for inpatient acute care discharges on or after January 1, 2016, county-owned hospitals, as defined in Section 148.25(a)(1), shall be reimbursed at allowable cost on a DRG basis. The DRG base payment shall be the product, rounded to the nearest hundredth, of:

1) The DRG weighting factor of the DRG and SOI (severity of illness), to which the inpatient stay was assigned by the grouper.

2) The DRG base rate determined:

A) Prior to July 1, 2018, such that simulated base period as defined in subsection (a)(3) DRG payments are equal to adjusted base period costs, as determined in subsection (a)(1)(A)(ii); and

B) Effective July 1, 2018, such that simulated DRG payments are equal to inpatient base period costs inflated to the rate period, based on inpatient based period claims data, less an amount calculated in Section 148.406(c).

(Source: Amended at 42 Ill. Reg. 22401, effective November 29, 2018)