**Section 148.122 Medicaid Percentage Adjustments**

Effective for dates of service on or after July 1, 2014, unless another date is specified, the Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1 of each year unless otherwise noted.

a) Qualified Medicaid Percentage Hospitals. The Department shall make adjustment payments to hospitals that are deemed as a Medicaid percentage hospital by the Department. A hospital, except those that are owned or operated by a unit of government, may qualify for a Medicaid Percentage Adjustment (MPA) in one of the following ways:

1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section 148.120(i)(4), is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section 148.120(i)(3).

2) The hospital's low income utilization rate, as defined in Section 148.120(i)(6), exceeds 25 per centum.

3) Illinois hospitals that, on July 1, 1991, had an MIUR, as defined in Section 148.120(i)(4), that was at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3), and that were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (see 77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (see 42 CFR 5 (1989)).

4) Illinois hospitals that meet the following criteria:

A) Have an MIUR, as defined in Section 148.120(i)(4), that is at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3).

B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(3), that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(2).

5) Any children's hospital, as defined in Section 148.25(d)(3).

6) Out of state hospitals meeting the criteria in Section 148.120(e).

7) A hospital that reopened a previously closed hospital facility, which includes hospitals that have been terminated from participation in the medical assistance program in accordance with 305 ILCS 5/12-4.25, within 4 calendar years of the hospital facility's closure.

b) In making the determination described in subsections (a)(1) and (a)(4)(A), the Department shall utilize the data described in Section 148.120(c) and received in compliance with Section 148.120(f). Effective for Medicaid Percentage rate year 2024 and thereafter, the Medicaid Inpatient utilization rate, as defined in Section 148.120(i)(4) and used in the determination of eligibility for payments under subsection (d), shall be modified to exclude from both the numerator and denominator, all days of care provided to military recruits or trainees for the United States Navy and covered by TRICARE or its successor.

c) Hospitals that qualified as an MPA hospital under subsection (a)(2) for the Medicaid percentage determination year beginning October 1, 2013 may apply annually to become qualified under subsection (a)(2) by submitting audited certified financial statements as described in Section 148.120(d) and received in compliance with Section 148.120(f).

d) Medicaid Percentage Adjustments. The adjustment payments required by subsection (a) for qualified hospitals shall be calculated annually as follows for hospitals defined in Section 148.25(b)(1), excluding hospitals defined in Section 148.25(a).

1) The payment adjustment shall be calculated based upon the hospital's MIUR, as defined in Section 148.120(i)(4), and subject to subsection (e), as follows:

A) Hospitals with an MIUR below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;

B) Hospitals with an MIUR that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's MIUR exceeds the mean Medicaid inpatient utilization rate;

C) Hospitals with an MIUR that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's MIUR exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

D) Hospitals with an MIUR that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

E) Hospitals that reopen a previously closed hospital facility within 4 calendar years of the hospital facility's closure, if the previously closed hospital facility qualified for payments under subsection (d) at the time of closure, shall receive the rate in place at the time of the closure until utilization data for the new facility is available for the Medicaid inpatient utilization rate calculation.

2) The MPA payment, calculated in accordance with this subsection (d), to a hospital shall not exceed $155 per day for a children's hospital, as defined in Section 148.25(d)(3), and shall not exceed $215 per day for all other hospitals.

3) The amount calculated pursuant to subsections (d)(1) through (d)(2) shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) hospital cost index from DSH determination year 1993, as defined in Section 148.120(i)(2), through DSH determination year 2003 and annually thereafter, by a percentage equal to the lesser of:

A) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

B) The percentage increase in the Statewide average hospital payment rate, over the previous year's Statewide average hospital payment rate.

4) The amount calculated pursuant to subsections (d)(1) through (d)(3) shall be the inpatient payment adjustment in dollars for the applicable Medicaid percentage determination year. The adjustments calculated under subsections (d)(1) through (d)(3) shall be paid on a per diem basis and, except as provided in subsection (d)(5), shall be applied to each covered day of care provided.

5) Covered days associated with claims for normal newborn DRGs 626 or 640 are not eligible for the MPA adjustment or the per diem payments on adjustments calculated under subsections (d)(1) through (d)(3).

e) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Section 148.25(d)(3), the payment adjustment calculated under subsection (d)(1) shall be multiplied by 2.0.

f) Medicaid Percentage Adjustment Limitations

1) In addition, to be deemed an MPA hospital, a hospital must provide to the Department, in writing, 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 federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform obstetric services at the hospital. This requirement for obstetric services does not apply to a hospital:

A) In which the inpatients are predominantly individuals under 18 years of age;

B) That does not offer non-emergency obstetric services as of December 22, 1987; or

C) That was providing obstetric services prior to February 1, 2019 and discontinues obstetric services after February 1, 2019 and is located within 15 miles of a hospital that continues to provide obstetric services at the time of discontinuation. Hospitals that do not offer obstetric services to the general public, with the exception of those hospitals described in Section 148.25(d), must submit a statement to that effect that includes the date obstetric services were discontinued.

2) Hospitals that qualify for MPAs under this Section shall not be eligible for the total MPA if, during the MPA determination year, the hospital discontinues provision of obstetric services. The provisions of this subsection (f)(2) shall not apply to those hospitals described in Section 148.25(d) or those hospitals that have not offered obstetric services as of December 22, 1987, or those hospitals that discontinue obstetric services after February 1, 2019 and are located within 15 miles of a hospital that continues to provide obstetric services at the time of discontinuation. In this instance, the adjustments calculated under subsection (d) shall cease to be effective on the date that the hospital discontinued the provision of obstetric services.

3) Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), that result in a change in a hospital's eligibility for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage 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 Medicaid Percentage payment adjustments based upon the requirements of this Section.

4) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for Medicaid percentage payment adjustments under this Section shall not be eligible for Medicaid percentage payment adjustments if the hospital's MIUR, as defined in Section 148.120(i)(4), is less than one percent.

g) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:

1) "Medicaid Percentage determination year" has the same meaning as the DSH determination year defined in Section 148.120(i)(2), except that:

A) The Medicaid Percentage determination year that begins on October 1, 2022 will end on December 31, 2023; and

B) Effective January 1, 2024, Medicaid Percentage determination years will begin on January 1 and end on December 31.

2) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4), provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in subsection (g), for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid percentage determination year and contained within the Department's paid claims data base.

3) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4), provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. 1396a), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (g), provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base.

4) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days that were subsequently adjudicated by the Department through the last day of June preceding the MPA determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act (specifically excluding Medicare/Medicaid crossover claims), with a Diagnosis Related Grouping (DRG) of:

A) 370 through 375 for claims adjudicated before July 1, 2014; or

B) 540, 541, 542 or 560 for claims adjudicated on or after July 1, 2014.

5) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (g)(2) and (g)(3), means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

6) "Medicaid obstetrical inpatient utilization rate base year" means, for example, fiscal year 2002 for the October 1, 2003 MPA determination year; fiscal year 2003 for the October 1, 2004 MPA determination year; etc.

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

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