**Section 149.100 Methodology for Determining DRG PPS Payment Rates**

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

a) Inpatient hospital services that are not excluded from the DRG PPS pursuant to Section 149.50(b) shall be reimbursed as determined in this Section.

b) Total DRG PPS Payment. Under the DRG PPS, services to inpatients who are:

1) Discharges shall be paid pursuant to subsection (c).

2) Transfers shall be paid pursuant to subsection (g).

3) The total payment for an inpatient stay will equal the sum of the payment determined in subsection (c) or (g), as applicable, and any applicable adjustments to payment specified in 89 Ill. Adm. Code 148.290.

c) DRG PPS Payment for Discharges. The reimbursement to hospitals for inpatient services based on discharges shall be the product, rounded to the nearest hundredth, of the following:

1) The greater of:

A) 1.0000; or

B) highest policy adjustment factor, as defined in subsection (f), for which the inpatient stay qualifies.

2) The sum of the DRG base payment, as defined in subsection (d), and any applicable outlier adjustment, as determined in Section 149.105, for which the claim qualifies.

d) For in-state (as defined in Section 148.140), non-Large Public Hospitals, the DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:

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

2) The DRG base rate, equal to the sum of:

A) The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare inpatient prospective payment system (IPPS) wage index, in-state standardized amount and graduate medical education (GME) factor.

B) The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the in-state standardized amount and the GME factor.

3) Effective July 1, 2018, for out-of-state, cost reporting hospitals, the DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:

A) The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the DRG grouper; and

B) The DRG base rate, equal to the sum of:

i) The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare IPPS wage index, the out-of-state standardized amount and the GME factor.

ii) The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the out-of-state standardized amount and the GME factor.

e) Medicare IPPS Wage Index. For purposes of this Section, the Medicare IPPS wage index is determined based on:

1) For Medicare IPPS hospitals that are in-state or are out-of-state Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the wage index is based on the Medicare IPPS hospital post-reclass wage index effective October 1, 2012.

2) For in-state non-Medicare IPPS hospitals and out-of-state non-Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the wage index is based on the Medicare IPPS wage index for the hospital's Medicare CBSA effective October 1, 2012.

f) Policy Adjustments. Claims for inpatient stays that meet certain criteria may qualify for further adjustments to payment.

1) Transplantation Services

A) Policy adjustment factor: 2.11.

B) Qualifying Criteria

i) The hospital meets all requirements to perform transplantation services, including but not limited to those detailed in 89 Ill. Adm. Code 148.82.

ii) The claim has been grouped to one of the following DRGs:

001 Liver transplant.

002 Heart and/or lung transplant.

003 Bone marrow transplant.

006 Pancreas transplant.

440 Kidney transplant.

2) Trauma Services

A) Policy adjustment factor:

i) 2.9100, if the hospital is a level I trauma center.

ii) 2.7600, if the hospital is a level II trauma center.

B) Criteria:

i) Hospital is recognized by the Department of Public Health as a level I or II trauma center on the date of admission.

ii) The claim has been grouped to one of the following DRG:

020 Craniotomy for trauma.

055 Head trauma, with coma lasting more than one hour or no coma.

056 Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.

057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.

135 Major chest and respiratory trauma.

308 Hip and femur procedures for trauma, except joint replacement.

384 Contusion, open wound and other trauma to skin and subcutaneous tissue.

841 Extensive third degree burns with skin graft, as of July 1, 2018.

842 Full thickness burns with graft, as of July 1, 2018.

843 Extensive burns without skin graft, as of July 1, 2018.

844 Partial thickness burns with or without graft, as of July 1, 2018.

910 Craniotomy for multiple significant trauma.

911 Extensive abdominal/thoracic procedures for multiple significant trauma.

912 Musculoskeletal and other procedures for multiple significant trauma.

930 Multiple significant trauma, without operating room procedure.

3) Perinatal Services

A) Policy adjustment factor:

i) 1.3500, if the DRG to which the claim is grouped has an SOI of 1.

ii) 1.4300, if the DRG to which the claim is grouped has an SOI of 2.

iii) 1.4100, if the DRG to which the claim is grouped has an SOI of 3.

iv) 1.5400, if the DRG to which the claim is grouped has an SOI of 4.

B) Criteria:

i) Hospital was recognized by the Department of Public Health as a level III perinatal center on the date of admission. Effective July 1, 2018, hospital was recognized by the Department of Public Health as a level II or II+ or III perinatal center on the date of admission.

ii) The claim has been grouped to one of the following major diagnostic categories (MDC):

14 Pregnancy, childbirth and puerperium.

15 Newborn and other neonates.

4) Safety Net

A) Policy adjustment factor: $57.50 per general acute care day.

B) Qualifying criteria: safety-net hospital defined in 305 ILCS 5/5-5e.1 excluding pediatric hospitals as defined in 89 Ill. Adm. Code 148.25(d)(3).

C) Effective: for dates of service on and after July 1, 2014.

5) Crossover Adjustment Factor effective July 1, 2018. DRG standardized amounts, as defined in subsection (i), shall be reduced by a Crossover Adjustment factor such that:

A) The absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment factor to simulated DRG payments, including Policy Adjustments, using general acute hospital inpatient base period claims data, is equal to:

B) The difference of: total simulated DRG payments using general acute hospital inpatient crossover claims data, and general acute hospital inpatient crossover claims data total reported Medicaid net liability.

g) DRG PPS Payment for Transfers. The reimbursement to hospitals for inpatient services provided to transfers shall be the lesser of:

1) The amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge; or

2) The product, rounded to the nearest hundredth, of the following:

A) The quotient resulting from dividing the amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge by the DRG average length of stay for the DRG to which the inpatient claim has been assigned.

B) The length of stay plus the constant 1.0.

h) Updates to DRG PPS Reimbursement. The Department may annually review the components listed in subsection (c) and make adjustments as needed. Grouper shall be updated at least triennially and no more frequently than annually.

i) Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to 89 Ill. Adm. Code 148.105, 148.115, 148.126, 148.295, 148.296 and 148.298 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in rule as of February 21, 2014 (see https://www.illinois.gov/hfs/medicalproviders/hospitals/

hospitalratereform/Pages/default.aspx), as determined by the Department, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Allowed amounts", effective July 1, 2018, means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for fiscal year 2015 MCO encounter data adjusted with a completion factor and fee-for-service claims data, excluding Medicare dual eligible claims.

"Discharge" means a hospital inpatient that:

has been formally released from the hospital, except when the patient is a transfer; or

died in the hospital.

"DRG" means diagnosis related group, as defined in the DRG grouper, based on the principal diagnosis, surgical procedure used, age of patient, etc.

"DRG average length of stay" means, for each DRG and SOI combination, the national arithmetic mean length of stay for that combination rounded to the nearest tenth, as published by 3M Health Information Systems for the DRG grouper.

"DRG grouper" means:

Prior to January 1, 2014, the most recently released version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during which the discharge occurred.

Effective January 1, 2014, version 30 of the APR-DRG software.

Effective July 1, 2018, DRG grouper version 33 of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems.

"DRG PPS" means the DRG prospective payment system described in this Part.

"DRG weighting factor" means each DRG and SOI combination shall equal the product, rounded to the nearest ten-thousandth, of the national weighting factor for that combination, as published by 3M Health Information Systems for the DRG grouper and the Illinois experience adjustment.

"GME factor" means the Graduate Medical Education factor applied to major teaching hospitals, as defined in 89 Ill. Adm. Code 148.25(h). Simulated payments under the new inpatient system with GME factor adjustments shall be $3 million greater than simulated payments under the new inpatient system would have been without the GME factor adjustments, using inpatient base period paid claims data.

"Illinois experience adjustment" means:

for the calendar year beginning January 1, 2014, a quotient, computed by dividing the constant 1.0000 by the arithmetic mean 3M APR-DRG national weighting factors of claims for inpatient stays subject to reimbursement under the DRG PPS using inpatient base period paid claims data, rounded to the nearest ten-thousandth;

for subsequent calendar years, the factor applied to 3M APR-DRG national weighting factors, when updating DRG grouper versions determined such that the arithmetic mean DRG weighting factor under the new DRG grouper version is equal to the arithmetic mean DRG weighting factor under the prior DRG grouper version using inpatient base period claims data.

"Inpatient base period claims data" means:

Prior to July 1, 2018, State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for DRG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, the most recently available adjudicated 12 months of inpatient paid claims data to be identified by the Department.

Effective July 1, 2018, State fiscal year 2015 inpatient Medicaid claims data allowed amounts, for DRG PPS payment for services provided in State fiscal years 2019 and 2020 for subsequent dates of service, the most recently available adjudicated 12 months of inpatient paid claims data to be identified by the Department.

"Inpatient stay" means a formal admission into a hospital, pursuant to the order of a licensed practitioner permitted by the state in which the hospital is located to admit patients to a hospital that requires at least one overnight stay.

"In-state standardized amount", effective July 1, 2018, means, for all Illinois hospitals and out-of-state hospitals that are designated a level I pediatric trauma center or a level I trauma center by the Illinois Department of Public Health as of December 1, 2017, the average amount as the basis for the DRG base rate established by the Department, such that simulated DRG PPS allowed amounts, less PA 97-689 reductions, results in approximately a $238.5 million increase inclusive of policy adjustors effective July 1, 2018, as defined in subsections (f)(2) and (f)(3), compared to the sum of the inpatient based period claims data allowed amounts.

"Length of stay" means the number of days the patient was an inpatient in the hospital, with the day the patient became a discharge or transfer not counting toward the length of stay.

"Medical assistance" means one of the programs administered by the Department that provides health care coverage to Illinois residents.

"Medicare CBSA" means the Core-Based Statistical Areas for a hospital's location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

"Medicare IPPS labor share percentage" means the Medicare inpatient prospective payment system operating standardized amount labor share percentage for the federal fiscal year ending three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the labor share percentage in the Medicare inpatient prospective payment system for the federal fiscal year beginning October 1, 2012, which is 0.6880 for a hospital with a Medicare IPPS wage index greater than 1.0 or 0.6200 for all other hospitals.

"Medicare IPPS non-labor share" means the difference of 1.0 and the Medicare IPPS labor share percentage.

"MDC" means major diagnostic category – group of similar DRGs, such as all those affecting a given organ system of the body.

"Out-of-state standardized amount", effective July 1, 2018, means, for cost-reporting hospitals located outside of Illinois that are not included in the in-state standardized amount definition, the average amount as the basis for the DRG base rate established by the Department, such that simulated DRG PPS allowed amounts, without PA 97-689 reductions or GME factor adjustments, using general acute hospital inpatient based period claims data, are equal to the sum of inpatient based period claims data allowed amounts.

"SOI" means one of four subclasses of each DRG, as published by 3M Health Information Systems for the DRG grouper that relate to severity of illness (the extent of physiologic decompensation or organ system loss of function experienced by the patient) and risk of (the likelihood of) dying.

"Statewide standardized amount" means the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS payments, without P.A. 97-0689 reductions or GME factor adjustments, using general acute hospital inpatient based period paid claims data, are $355 million less than the sum of inpatient based period paid claims data reported payments and allocated inpatient static payments.

"Transfer" means a hospital inpatient that has been placed in the care of another hospital, except that a transfer does not include an inpatient claim that has been assigned to DRG 580 (Neonate, transferred, less than five days old, not born here) or 581 (Neonate, transferred, less than five days old, born here).

(Source: Amended at 42 Ill. Reg. 22533, effective November 28, 2018)