Sections	Comments/Questions	Response
Section 149.100 (f)(1)(B)(ii)	the categories of DRG that identify the various transplants, is there a specific APR DRG for a kidney / pancreas transplant? There is one for M/S DRG, I wondered if there was one for APR DRGS?	The APR-DRG system does not have simultaneous kidney/pancreas transplant grouping. If both occur during the same operation, the severity of illness assignment and outlier payments should reflect the complex operation.
Section 149.100 (f)(2)(ii),	should level 2 trauma centers policy adjustment factor be 2.76? This is what is listed under model components for model C9 that you gave out Friday.	Yes.
Section 149.100 (f)(3)(i) thru (iv),	should the policy adjustment factors for Perinatal services be 1.35, 1.43, 1.41, and 1.54 respectively as stated in model C9 model components?	Yes.
Section 149.100 (i),	Definitions, should the "Statewide standardized amount " be $3,306.89 per the model components of model C9?	Yes.
Section 148.140(e)(3)(A) and (B),	did we have a discounting factor of 0.75 for criteria (A) and (B)? I didn't see it in the model components for OP under either model C8 or C9? I see the discounting of 0.50 Multiple procedure discounting flag and I see the discounting factor of 1.50 for Bilateral Procedure Discounting but not the 0.75?	Yes, there is a discount to .75 when: (A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and (B) The service has been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

Section 148.297	Physician Development Incentive Payments, will this eventually have the GME payment allocation rules? I don't see them.	The GME rate payment has been incorporated into section 149.100.
148.440 through 148.458 and 148.464 through 148.486	HFS should not include changes for 148.440 through 148.458 and 148.464 through 148.486. These changes are irrelevant to rate reform and unnecessary under current law.	HFS chose to include the changes as presented.
☐ **Part 140 Sections 16,402,461,464,930 Table J, and Table M** ☐ **Part 146 Sections 100-125** ☐ **Part 148 Sections 20, 85,90,95,103, 150, 175, 330, 370, 390, 400, 460, 462, 860, and Table C**	Several sections are changes or clean-up not related to rate reform. These should be submitted separately.	HFS chose to clean up rules language that no longer applies to hospital reimbursement, references sections that are being repealed or changed in this rule making, or needed updating or clarification.
Graduate medical Education (GME) payments and SECTION 148.297 PHYSICIAN DEVELOPMENT INCENTIVE PAYMENTS	I and others have advocated for GME payments to be part of the reformed system I also request that all GME payments be tied to utilization.	The Department agreed to place $3M in rates and $3M in supplemental payments based on the development of primary care physicians. The Department received no proposal that did this.
Outpatient system adjustments for expensive medical devices and drugs	HFS or Navigant has done which shows how the EAPG does or does not account for the costs for these items.	The Department distributed the EAGP relative weights to the TAG on 1/27/14.
Perinatal level 2 and 2+ recognition	I request that HFS add a tiered adjuster for these two level of perinatal facilities for consistency with the concept of recognize special designations.	The TAG advised the Department on a perinatal level 3 adjustor. The Department has included that adjustor. Any additional policy adjustors will lower the base rate across all hospitals.
SECTION 148.82 ORGAN TRANSPLANT SERVICES	Paying less for organ transplants under a reformed system is still a concern	The Department worked with the TAG extensively to develop the transplant methodology in an effort to move away from paying for a percentage of charges. The new methodology enhances payment by over double that assigned by the pure APR-DRG and the

		transplant claims are eligible for higher levels of outlier payments.
Ambulatory Surgical Treatment Centers (ASTCs)	It is unclear to me how these will be paid under the EAPG system	Section 148.140(d)(7) – The ASTC outpatient standardized amount is set so that ASTC reimbursement is budget neutral to current ASTC spend.
SECTION 148.25	Is there a rationale for using less than 50 beds to define a Children's specialty hospital? I think HFS should possibly review to see if Shriner's should be designated under this section. I agree with the inclusion of the AMC definition that is in law. Can HFS explain what is occurring with all the changes in these rules on Maternal and Child Health clinics? What is going on and how is it related to hospital rate reform?	Yes. The 50 bed criteria limits eligibility to La Rabida which is the only general acute hospital that is excluded from the APR-DRG as discussed for many months. The Department believes that there is no need for the Maternal and child health clinics designation.
SECTION 148.105	HFS has not supplied data on the calculation occurring under this section. Without the proper context and math I cannot evaluate if the verbiage correctly describes the calculation. Please provide additional information. HFS also describes the final rate as a transition rate. HFS has not indicated a plan to implement a different methodology so describing this as a transition rate is inappropriate. HFS should remove the word transition.	Transition is merely a word used to describe the rate. The Department has replaced 'transition' with 'rehabilitation'.
Section 148.110	HFS has not supplied data on the calculation occurring under this section. Without the proper context and math I cannot evaluate if the verbiage correctly describes the calculation. Please provide additional information. HFS has not replaced the word "rehabilitation" in several places with "psychiatric". HFS also describes the final rate as a transition rate. HFS has not indicated a plan to implement a different methodology so describing this as a transition rate is	The Department has made the changes to read 'psychiatric'. The Department has replaced 'transition' with 'psychiatric'.

	inappropriate. HFS should remove the word transition.	
SECTION 148.112	In moving MHVA from 148.290 to this section, HFS chose to simplify the rule. I understand the desire but instead of including the language on how MHVA is inflated HFS chose to simply reference the law. I request HFS make the rule clear by including the inflation language from the law rather than incorporating by reference. This adds transparency by making it easier for the reader to understand.	HFS chose to reference the law.
SECTION 148.122	Is HFS making material changes or just clean-up? The definition for low-income utilization is now referenced from the DSH section. Is the definition the same or has HFS changed? What is HFS' intent here?	The definition is the same. The department chose to reference instead of listing the same language twice.
SECTION 148.120	Are the changes in this section intended to make it more difficult to provide data to justify qualification? Is the low-income definition a change from current policy and federal law? It does not seem clear to me.	There is no intent to change the low income definition. The Department updated the language to maintain agreement with federal law.
SECTION 148.115	HFS should move to adopt Section 148.436 and then align this section based on that	The Department agrees that section 148.436 is needed to cover rates from 11/16/13 through 6/30/14 as 148.115 is not effective until 7/1/14.
SECTION 148.140	HFS has not supplied data on the calculation occurring under this section. Without the proper context and math I cannot evaluate if the verbiage correctly describes the calculation. Please provide additional information. In (a)(E) HFS references alternative methodologies under148.330. The reference section appears to allow some negotiated rates. What is HFS' intent here? As discussed previously above, I request HFS include a policy adjustment for expensive medical devices and drugs consistent with current policy. Please provide information and data on the calculation	148.330 gives the Department the ability to reimburse a hospital outside of the APR-DRG and EAPG systems if needed. The current outlier methodology on expensive drugs and devices is not being continued. As discussed through TAG meetings, the OP high volume adjustor is determined using all categories of service for OP institutional claims and the OP high volume adjustor is applied to all categories of service for OP institutional claims at those facilities that

	of the policy adjuster under paragraph (f)(2). If rehabilitation and psychiatric services have distinct standardized amounts why are they included with general acute outpatient services when calculating this policy adjuster? HFS has determined with a distinct standardized amount psychiatric and rehabilitation services are different but in the policy adjuster determined they are the same? HFS does not indicate the frequency or data used for determining this policy adjuster.	qualify. The Department does indicate the frequency and data used in determining the OP high volume policy adjustor in definition under 'High Volume Outpatient base period paid claims data'.
SECTION 148.296	HFS has not supplied data on the calculation occurring under this section. Without the proper context and math I cannot evaluate if the verbiage correctly describes the calculation. Please provide additional information.	The verbiage presented is consistent with the transitional pool payments as described and presented in the latest models distributed by the Department.
SECTION 149.105	There is a typographical error in (b)(3). Is outlier liability currently excluded in the determination of how much of the Medicare coinsurance/deductible is paid by Medicaid?	The Department deleted (b)(3).
SECTION 149.100	I reiterate previous comments above on policy adjusters. I am unable to evaluate this verbiage in this section as it relates to the actual calculation.	The verbiage presented is consistent with the methodologies presented to the TAG.
SECTION 140.11	Does this change affect existing hospital providers or only future enrollments? Please list current providers affected if it does.	The only change in this section is to correctly reference children's hospital definition and refer to the correct the name of the Federal certifying body.
SECTION 148.116	It is unclear what this special treatment of LaRabida means. No information has been provided to TAG other than LaRabida was being excluded from rate reform and treated uniquely once it was asked why LaRabida was missing from summary documents	A portion of La Rabida's supplemental rates will be moved into an updated per diem rate and the remaining amount will be continued as supplemental payments. OP services will be paid through the EAPG grouper.
Section 148.120	It appears these new Rules would make it much more difficult, if not impossible, for hospitals to provide supporting documentation for the DSH calculation	It is not the Department's intention.

148.120(i)(6)	The LIU calculation described in 148.120(i)(6) does not comport with the description provided in Federal Regulations which by Illinois law it must. Specifically, certain revenue sources such as revenue from State and local governments are excluded from the amended calculation. By undercounting revenue, this new calculation effectively raises the qualifying threshold. As written, these new DSH Rules represent a significant change from the current methodology. A methodology HFS stated it would not change. If implemented in its current form it would quite likely preclude current DSH hospitals from qualifying in future years.	There is no intent to change the low income definition. The Department updated the language to maintain agreement with federal law.
148.25		
	(b)(5) Citation 140.464 does not appear to be correct. 140.930 would now appear to be the correct citation for reimbursement for Maternal and Child Health. Prior to striking out 140.461(f) referenced Maternal and Child Health Clinics, (f) now references School Based / Linked Clinic. (b)(5) appears to be focused on Maternal and Child Health Clinics. Is the repeal correct or is the reference to (f) incorrect	The Department deleted 148.25(b)(5).
	(c) Does the definition of a DPU in (c) conflict with the definition (d) specialty hospital? How will this be interpreted with respect to Kindred hospitals that have behavioral health?	The Department deleted the clause pertaining to specialty hospitals.

	Suggest deleting reference to specialty hospital in (c)(1)	
	(d)(3) Children's Hospital definition This definition would not cover the Free-Standing Pediatric Psych facilities, that the Department currently acknowledges. Especially for MPA / MHVA Reference to Rural hospitals is deleted. This reference is used in the Hospital Assessment program payments.	The Department added 'psychiatric' to 148.25(d)(3)(A) to include childrens psychiatric hospitals in the childrens hospitals definition. Rural hospitals is now defined in 148.446(a)(1).
	(g) Suggest inserting Illinois before Department of Public Health. – drafting consistency.	HFS chose to submit the changes as presented.
	(i) Specialty hospital appears to be designated for La Rabida only. Does this definition cover any other hospitals?	Correct. La Rabida is the only hospital that currently qualifies as a children's specialty hospital.
148.30:	(b) reference to subsection seems incorrect? Should it say section?	The Department made the correction.
148.40:	(4) Changing shall to may makes payment for psychiatric care optional; not required. This change seems to be a shift in policy that has not been discussed with the behavioral health community.	The Department made the correction.

	(c) ESRDT. Hospital definition is not contained in 148.140(f) appears reference should be 148.25(b). 148.40(f) appears to be part of the E-APG pricing logic	The Department made the correction. The Department removed the language.
148.70 (g)	Recommend the Department re-write, possible suggestion: The Department shall apply the appropriate edits to assure that the presence of a hospital acquired condition (HAC) does not result in an increase in payment. Technically, non-consideration of the HAC diagnosis and Procedures is not a reduction.	HFS chose to submit the changes as presented.
148.100:	With the increased penetration of MCE coverage it seems timely to update the definition of qualified claims to include services paid for through Managed Care entities.	Additional language inserted to include utilization for individuals covered by MCEs to be included in the calculation.
148.105:	(f) Allocated static payments reference should be 148.105, 148.115, 148.117, 148.126, 148.295, 148.296 and 148.298. All references to transition rate – request transition be removed and simply state either rate or per diem rate. (c)(1) “weighted” is misspelled Section needs a definition and calculation for	The Department made the correction. The Department removed the word transition and replaced with ‘rehabilitation’. Spelling corrected. Default language has been inserted.

	statewide default rate that would be applied to new providers.	
148.110:		
	(f) Allocated static payments reference should be 148.105, 148.115, 148.117, 148.126, 148.295, 148.296 and 148.298. All references to transition rate – request transition be removed and simply state either rate or per diem rate. Section needs a definition and calculation for statewide default rate that would be applied to new providers	The Department made the correction. The Department removed the word transition and replaced with 'psychiatric'. Default language has been inserted.
148.112		
	(d) Definitions The terms "MHVA base fiscal year" and "MHVA rate period" do not appear anywhere in the section, other than in the definition subsection.	The Department removed the terms.
148.115		
	The Department has a pending rule implementing a new section "148.436" on long term acute care hospital reimbursement. Has this rule been adopted? Shouldn't that rule be modified instead of inserting a new 148.115? (e) Allocated static payments reference should be 148.105, 148.115, 148.117, 148.126, 148.295, 148.296 and 148.298.	148.436 has not yet been adopted. 148.115 has been modified to reflect 148.436. The Department made the correction. Allocation language is needed.

	(e) Not sure charge allocation language is needed. Section needs a definition and calculation for statewide default rate that would be applied to new providers.	Default language has been inserted.
148.116		
	Construction of section needs work. Subsection (a) refers to inpatient per diems (a)(1) Should be a new subsection (b) outpatient reimbursement (a)(2) Should be a new subsection (c) transitional payments Is it the department's intent to consider all transitional payment to children's specialty hospitals as Outpatient for purposes of the UPL? (a)(3) makes reference to itself (a)(3)	The Department has made the corrections.
148.117		
	As some payments in this section are being modified to become effective in March, 2014 the effective date of this rule cannot be July 1, 2014. Suggest that language inserting firm end dates instead of repeal language (crossouts). For ease of reading and a broader understanding, recommend that rule language insert end date instead of total repeal of payments.	Effective date language has been inserted. The Department chose to strike the language that will no longer be in effect. The Department included a link to the Department's website that will list the previous version of the rules for reference.
148.120		
	(c)(2)(C) Change HMO to MCE to be consistent. (i)(1) "Base year" suggest double checking the 34	The Department made the correction.

	month language. Ex. DSH determination year 2014 begins 10/2013 1/2013 – 9/2013 = 9 months 1/2012 – 12/ 2012 = 12 months 1/2011 – 12/2011 = 12 months Total = 33 months DSH year 2014 should be based on calendar year 2011	The Department made the correction.
	(i)(6) Low income utilization rate does not mirror the definition in 1923(b)(3) which include cash subsidies for patient services directly from state and local governments. Recommend mirroring the definition as is in 1923(b)(3).	The Department made the correction.
148.122		
	(c) Citation may need to begin "Only Hospitals that…… This would clarify the limitation to those hospitals grandfathered in under the LIU option for MPA.	HFS chose to submit the changes as presented.
	(d)(3) Suggest that language needs to be amended back to original language that mirrors statute.	The Department chose to reference the law.
	(d)(4) Adjustment eliminated appears to be the childrens adjustment which remains in place.	The Childrens adjustment remains in place in 148.122(e).
148.126 SNAP supplemental payments	How can this rule be applicable for one hospital getting FY14 rate increases on March 1 but all other changes are effective July 1. All payments being struck out are in effect until June 30, 2014. Do not believe this rule will work. For SNAP payments being adjusted and being extended, that are also being adjusted down, does	Effective date language has been added.

	the rule need to reflect a new effective date(s) of July 1, 2014 through December 31, 2014? (f) $47.50 per day, does not have a Dec. 2014 end date like all other edits. “through December 31, 2014.” is missing.	The Department made the correction.
148.140	General question: Currently, the Medicaid program has issued a list of services which can be billed through the Outpatient (APL) setting. Will this continue? Will HFS be publishing a new list of acceptable procedures? (HCPCS codes) No reference is made in the rules. (c) Would it be appropriate to say same episode of care vs. same day. Multiple significant procedures which occur the same day, but not associated with the same visit should not be discounted. This is especially important when an emergency room is part of the covered services package that included bundling. Emergency services can occur the same day as a scheduled outpatient episode and each visit should be considered independently. 3M language appears to have been used in the definitions section when defining EAPG, in which the term visit is used not same day.	Yes. The outpatient claims submitted through the EAPG must contain a HCPC code that is presently on the APL list. HFS chose to submit the changes as presented.

	(d)(1) and (2) References rates for Cook and U of I that are specified in sections 148.160 and 148.170. These sections are not included in the rule changes.	Sections 148.160 and 148.170 have been added.
	(e) (1) (B) same concern on “same day “ language (e) (2) (A) same concern on “same day “ language (e) (3) (B) same concern on “same day “ language (e) (4) (B) same concern on “same day “ language	HFS chose to submit the changes as presented.
	(f) Policy adjusters for safety net providers. Recommend shall replace may in the qualify statement.	
	(f) (2) Since Safety net hospital providers are separately identified, should they be added to the exception list like critical access and large public hospitals.	The Department made the correction. .
	(g) Recommend the Department confirm this policy. It is our understanding HFS is not utilizing the bundling method used by Medicare. It is our understanding that HFS is using a fixed rate that has not been updated for several years.	The Department made the correction. Reimbursement for ESRD services will remain unchanged from current policy.
	(h) The requested authority is too broad. Far too premature to grant unilateral authority to make adjustments as needed. If the intent is to update procedure list as clinical changes occur, this should be spelled out. Language as it stands could be interpreted to grant	HFS chose to submit the changes as presented.

	the Department authority to change rates, without adopting a new rule and being subject to JCAR Review.	
	(i) High volume outpatient qualifying criteria was based on claims not services	The Department made the correction.
	"Outpatient base period paid claims data" this infers that 2011 will be the basis for rates in 2015, 2016, 2017. Isn't it the Department's intent to rebase for the 2017 rate year, at the end of the proposed transition period?	It is the Department's intent to move transitional payments into the base rates for the FY 2017 rate year. It is the Departments intention to rebase for the FY 2018 rate year.
	The term "aggregate ancillary cost to charge ratio" is contained in the definition section (i) but does not appear anywhere else in 148.140.	The term appears in a later definition: "Estimated cost of outpatient base period claims data".
148.160 and 148.170	are not in the rules change but are referenced in the outpatient rule.	Sections 148.160 and 148.170 have been added.
148.180		
	(a) delete 148.100 reference and add 148.116	The Department made the correction.
148.210	(d) recommend the department remove. Provider assessments are an allowable Medicare cost, and the Department wants to rely on the Medicare cost reports.	The Department adjusted the language.
148.295		
	(a)(2)(C) Original adjustment is stated as an increase per day. The new rate effective 3-1-14 states a simple rate of $1,040. The rate is not stated as a per diem.	The Department made the correction.
	(a)(2)(D) Original adjustment is stated as an	The Department made the correction.

	increase per day. The new rate needs to be stated as a per diem. (a)(2)(F) Rate does not have an end date as all other supplemental rates do. How can this rule be applicable for some hospitals getting FY14 rate increases on March 1 but all other changes are effective July 1. All payments being struck out are in effect until June 30, 2014.	The Department made the correction. The Department added effective date language.
148.296	(a)(2)(B) reference should be (A) not #1, (e) should be (c) (e)(c) (1) recommend adding payment frequency statement. "monthly equal to 1/12 of the annual amount of the transitional supplemental payment calculated in (b) (e) (2) Recommend July 2015 to begin convening TAG (e)(3) Recommend (a) the total of all new supplemental payments identified in (e)(2) plus the value of increases to inpatient or outpatient rates shall be no less than the total of all supplemental payments authorized under part 148 during fiscal year 2015 and 2016, following the implementation of the APR DRG and EAPG system, divided by 2.	The Department made the corrections. The Department changed the date to October 2015. The Department chose not to include this language. .
148.300	(c) transitional payments defined in 148.296 should be excluded from this provision.	The Department chose not to change the language.
148.310 (a)	The Department should be required to supply full documentation of all data and full calculation of all rate determinations to any requesting hospital.	148.310 list the review procedures.

	The review period should begin only once the department has supplied hospitals with the detailed calculation of any rate	
148.320	(a) the intent and purpose is not clear.	The Department repealed this section.
148.440 – 148.486	are not germane to rate reform. All payments outlined are sunset in Illinois statute. Statute takes priority over administrative rule.	The Department chose not to change the language.
Remainder of Part 148 relate to assessment payments, which reference rules being deleted.	If assessment payments reference repealed language, is there any concern that the authority to make Assessment payment will be questioned or diminished? Some assessment funded payment amounts are based on payments in rules being repealed.	The Department added language to clarify. The Department is including a link to the Department's website that will list the previous version of the rules for reference.
Part 149 **149.75 (d)**	Updated medical review language is not germane to rate reform. Inclusion of the term "at the sole discretion of the Department" is more limiting than the current language and should be discussed or handled in another rules filing. Recommend removal at minimum of these 7 words, preferably the entire sentence. Unnecessary and not germane to rate reform.	The Department chose not to change the language.
149.100	(h) The requested authority is too broad. Far too premature to grant unilateral authority to make adjustments as needed.	The Department chose not to change the language.

	(i) definitions	The Department added language to clarify.
	"Allocated static payments" reference should be 148.105, 148.115, 148.117, 148.126, 148.295, 148.296 and 148.298 "Inpatient base period paid claims data" this infers that 2011 will be the basis for rates in 2015, 2016, 2017. Why would the base period not be updated if rates can be modified in 2017? "Statewide Standardized Rate" – Needs work. Recommend less specificity about the $355 M.	It is the Department's intent to move transitional payments into the base rates for the FY 2017 rate year. It is the Departments intention to rebase for the FY 2018 rate year. The Department chose not to change the language.
149.105		
	(b)(3) X-Overs should not be excluded from having outliers calculated. Outliers should be considered when determining the Department's liability to compare to Medicare Co-pays / Deductibles.	The Department removed 149.105(b)(3).
	(d) Definitions "Cost-to-charge ratio" why is the reference included, that the CCRs will be adjusted by the change in the CMS input price index?	The Department removed 'Cost to Charge ratio" from the definitions.
	Language infers that the FLT will be updated after FY 2014.	It is the Department's intent to updated the fixed loss threshold annually.
Part 152 **152.100**	Since SMART Act reductions have been accounted for on both sides of the final model, including the determination of the transitional pool payments, recommend additional exception to the SMART Act reductions.	The Department made the correction.
152.150		

	A technical discussion of the documentation coding and improvement methodology has never been discussed with the TAG. This language is not necessary to implement the new reimbursement system on July 1, 2014 Recommend that HFS delay proposing this until the TAG has had sufficient time to discuss and evaluate the proposal. Use of the MS-DRGs as a baseline may or may not be the appropriate metric. A demonstration of the methodology, by Navigant, should be shared with the TAG. If the methodology is sound and acceptable, filing rule at a later time will not have a negative impact on the Department's ability to implement. HFS should also consider alternatives, such as prospective adjustments. Retrospective adjustments will result in pay back of federal dollars possibly increasing fiscal pressures on the state. Serious discussion about the DCI factors that apply to the APL – EAPG transition need to occur. The current system is not a severity of care weighted system. There are no current weights to measure a baseline from.	The Department is filing rules regarding coding and document improvement that are consistent with methods discussed with the Technical Advisory Group.
Missing language:	The rules include a supplemental payment for physician development, but no discussion of a GME factor applied to claims payments.	Language has been added to section 149.100 to incorporate $3M in GME into the base rates for major teaching hospitals.

	A proposal was submitted to HFS addressing the GME rate adjustment. We respectfully request that HFS reconsider this approach and incorporate in the rules. There does not appear to be a reference to pricing logic proposed by HFS for services dually covered by Medicare and Medicaid. (Crossovers)	Language has been added to 148.140 to address the payment of dual Medicare / Medicaid crossover claims.
	The EAPG system appears to not appropriately recognize expensive medical devices or drugs. HFS has not provided any data disputing this point.	The Department provided the EAPGs and relative weights to the TAG on 1/27/14.
	GME payments – HFS has ignored the IHA proposal and chosen to water down the little infused into claims payments by spreading more broadly. Additionally, HFS has drafted a play for static payments that appear to not qualify for federal financial participation under title XIX.	The Department has allocated $3M for GME into the rates of major teaching hospitals and proposed a static piece consistent with stated goals.
	The inconsistency of recognizing high costs of maintaining specialty designation for perinatal level 2 and 2+ while recognizing both trauma designations.	The Department modeled policy adjustors for trauma and perinatal centers as recommended by the TAG over the past several months.
SECTION 152.150 HOSPITAL PAYMENT DOCUMENTATION AND CODING IMPROVEMENT ADJUSTMENT	What about the ICD-10 conversion? What assumptions does HFS make on how the effect of ICD-10 conversion has on DCI? How can those effects be isolated? The adjustment to inpatient and outpatient rates under (a)(4) and (b)(4) I believe are allowed either as an increase or a decrease. I think the language needs to be made clearer in this section on how the adjustments are being made. For outpatient, the base for comparison is the derived weights for the current APL system.	The Department believes that the incentives for documentation and coding improvement (DCI) will not be driven solely to the Department's implementation of the APR-DRG and EAPG models, and that the transition to ICD-10 will also require hospitals to change their coding practices. Even with this understanding, it will not be practicable for the Department to isolate future changes in payments attributable only to the ICD-10 conversion. As such, it is the Department's intent to consider the combined case mix measurement impacts of documentation and coding improvements associated with

		implementation of the new APR-DRG and EAPG payment methods and the ICD-10 conversion simultaneously.
	☐ Also the issue we are at odds with HFS on concerning expensive medical devices and drugs poses a problem under (b)(2)(A). Payments for those services are in 2011 base but unless HFS changes their position (which I encourage them to do) that will skew the comparison in favor of hospitals for the groups those items fall into.	The measurement of the case mix differential attributable to DCI will be an aggregated analysis. If a DCI-related adjustment to the EAPG conversion factor is required, either upward or downward, the adjustment factor will be the same for all hospitals, and therefore should not skew resulting future payments in favor of any particular group of providers. It is the Department's position that including legacy outpatient outlier payments associated with expensive medical devices and drugs in the determination the APL relative weights will facilitate the most comprehensive measurement of the case mix change under the legacy APL system. Since these expensive medical devices and drugs will be a component of measuring the case mix change under EAPGs, it is the Department's position that it would be most appropriate to include them in the determination of the case mix change under the APL system as well.
	☐ Grouping new claims to the APL for setting the baseline will require HFS and hospitals to update the APL list for any new procedure codes or changes from 2011.	The Department understands that measuring case mix increases under the APL methodology in future periods will require mapping new procedure codes to (both ICD-9 and ICD-10) to the current APL categories.
SECTION 140.71	HFS in these draft rules included new language related to the Long Term Acute Care Hospital Quality Improvement Transfer Program Act. HFS did not add the relevant legislative requirement to this section. I request the following	The Department made the correction.

	change be made per 201 ILCS 155/50 (j): "(b) Expedited Claims Payments (1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital qualified and participating under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [201 ILCS 155], a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:"	
148.140	I don't see a figure for the base rate for the EAPG system. Am I missing it, or has it not been published?	The base rate is not in rule. Per the 2011 Model C 9 handout on 1/17/14, the EAPG standardized amount for the most recent model that was distributed = $361.47. That rate, however, is subject to change with any alterations applied to that model.
148,110, (d)(1)(a), and (f)	Psych rules refer to rehab rates by mistake.	The Department made the corrections.
Section 148.140 Hospital Outpatient and Clinic Services	(Under "Exceptions to the all-inclusive EAPG PPS rate") We would like to recommend a provision that allows a hospital to bill for either the chemotherapy or the EAPG PPS when there are both chemotherapy and EAPG procedures provided during the encounter. This is consistent with current practices.	When an EAPG eligible service occurs on the same day as chemotherapy services, all services should be billed together on the same EAPG claim.

Question from Hospital Rate Reform Shadow Pricing Data Questions and Comments Log (Question 12 and 13) :	We would like to be able to utilize the G0379 code in lieu of the 99217 – 99218	The Department is looking into how the observation codes should be billed and will communicate billing requirements to the hospitals.
EAPG Drug/Implant Weights	We would like to request that HFS provide the EAPG Drug/ Implant weights; we believe that High Cost Drugs and Implants are not properly reimbursed under EAPG System-Model C-9.	The Department distributed the EAPGs and their respective weights to the Technical Advisory Group on 1/27/14.
	Although we understand that you are looking for comments on the draft and its consistency with model C.9, we would like to reiterate that we do not believe that the rules on GME constitute the best solution given the limited resources allotted. We believe the IHA's solution targeting Tier I and Tier II hospitals constitutes a better allocation of the resources.	The Department remains consistent with its approach of acknowledging the three tiers of teaching hospitals by incorporating the GME into their rates.
148.100	(b) (2) Medicaid trauma admission to include "adjudicated by the Department and adjudicated y a Managed Care Entity for discharges after June 30, 2014"	The Department added language to include claims for individuals covered by a MCE in the County Trauma determination.
148.105 and 148.110	Recognize the addition of a new distinct part units: For hospitals with a MIUR less than the mean plus ½ standard deviation, the new distinct part unit will receive the arithmetic mean transition rate for either psychiatric or rehabilitation distinct part units. For hospitals with an MIUR of ½ standard deviation or greater above the mean, the DPU will receive the arithmetic transition rate for rehabilitation or psychiatric distinct part units plus	The Department has inserted default language to set the default rate for new providers at the floors, to be consistent with the model to date.

	the value of two standard deviations of the rate for rehabilitation or psychiatric distinct part units.	
148.122	(f) (1) Suggest lifting the OB requirement if the hospital "can demonstrate that non-emergency obstetric services are available through an affiliated hospital determined to be a MPA qualified hospital less than eight (8) miles away."	The Department is not changing the OB requirements for MPA at this time.
148.296(c)(2)	Suggest adding: G) The financial implications of the loss of Transitional Supplemental Payments on Hospitals who are qualified to receive Transitional Supplemental Payments in excess of $10,000,000 and have an MIUR at least of one and one-half standard deviations above the mean.	The Department added the suggested language.
148.296	In subsection a) 1), providers should not qualify for Transitional Supplemental Payments if they are part of a system that, based on the shadowing exercise, is projected to receive more in reimbursement under the updated APR-DRG grouper than under the existing rate methodologies. Transitional Supplemental Payments should be limited to systems that will be receiving less under the updated APR-DRG grouper. The only exception to this revised rule should be for safety-net hospitals that are part of systems. Any funds reallocated with respect to the revision in comment 1. should be used to promote safety-net hospitals to no worse than breakeven and the balance should be reallocated to the pool for Transitional Supplemental Payments.	There was no consensus on either considering individual hospitals as systems, or on further capping those with projected gains, as under the current proposal, those with projected gains are funding the transitional payment pool through lowered rates.
	In subsections a) 2) and b), instead of attempting to describe a methodology, it seems more beneficial to	The language listed describes the methodologies used to calculate the transitional payments. It is necessary

	attach or reference the data submitted to the TAG. The TAG has no way to confirm the accuracy of the way the methodology was applied, but can and should be able to rely on the compilations presented. At the very least, the TAG data should be held out as a safe-harbor measure in the event the methodology described in the rule is flawed.	to list the methodologies in rule.
	We are unsure as to why there are not subsections c) or d). The draft rule jumps from b) to e).	The Department made the corrections.
	In subsection e), it would appear as though the Department is attempting to give itself the power to adjust Transitional Supplemental Payments without having to revisit the rules process, which we believe is not permissible. It is our understanding that any changes to these rules, including any reallocation of Transitional Supplemental Payments, must always be reviewed and approved by JCAR.	As discussed with TAG, the Transition payments will remain static for 2 years.
	Assuming the Department agrees with comment 5., the timing sequence proposed does not work. It would require the re-composed TAG to complete its work in a matter of days in order to have rules in place by 7/1/2016. Further, with almost 2 ½ years to complete, this process should never be undertaken as emergency rules.	The Department changed the date for commencing TAG discussions from 1/1/16 to 10/1/15.
	The rules should be written so that any rules adopted in 2014 remain in effect until replaced. If the Department intends to reconstitute the TAG in January, 2016, the rules should be amended at such time as there is a replacement methodology that has been thoroughly reviewed, and hopefully approved, by the TAG. The alternative (which is not	It is the intent that the APR-DRG and EAPG systems will be the long term reimbursement systems for hospital reimbursement. As discussed with the TAG, the proposed system will be evaluated and adjustments can be made at the end of the two year transition period.

	preferred) is to have the proposed rules sunset on June 30, 2016 to be replaced at that time by a replacement methodology.	
	In subsection e) 2), consideration should to be given to the impact on safety-net hospitals.	Language has been added for analysis of new hospital revenues and losses from all sources, which would include safety net hospitals.
	We are concerned that the rate reform model has inaccurately adjusted for the 3.5% hospital rate cuts imposed by Smart Act. As you are aware, those cuts were not to apply to safety net hospitals. However, we believe they have been modeled so that they were spread across the entire base.	While the department must be accurate in determining the funding pool for setting the rates which includes accounting for the SMART Act reductions, the Department has continuously modeled the safety net hospital payment amounts as immune from the 3.5% reductions imposed on the non-safety net hospitals. In addition, the proposed system grants an enhancement on outpatient services and allows for higher levels of transitional payments, all based solely on the safety net hospital designation.
	One of the changes discussed on the recent TAG call is a $6 million allocation for GME. When we met, we discussed the need for funding to support training for primary care physicians, particularly at inner city hospitals. To that end, we are anxious to review the Department's proposal.	HFS continues to advocate for $3M for GME in inpatient rates, as requested by IHA and the teaching hospitals, and $3M to support training for primary care physicians, as requested by the safety-net hospitals.
	We are concerned that the department is limiting the application of rate reform to the period ending June 30, 2016 without any plan for what the replacement system will be. This current exercise has extended for over two years and remains open ended. Among other things, that suggests the modeling for the 2016 rates should have begun already.	As stated to the TAG and in rule, there needs to be an analysis after the first year that considers all revenues and losses for all sources, so that appropriate adjustments can be made. With the many changes occurring in the healthcare system, it would be premature and highly speculative to begin modeling 2016 rates.

	Given the fact that the recent pension reform bill will free up approximately $1.5 billion in new funding, why doesn't the Medicaid program pursue revenues necessary to avoid projected cuts?	That law is now being challenged in several courts, and it is unlikely that the General Assembly will authorize spending from those funds. However, the state is seeking additional revenue from the 1115 Waiver, for hospitals as well as for community-based services needed by hospitals.