**Section 149.105 Payment For Outlier Cases**

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

a) Outlier adjustment determination. Except as provided in subsection (b), the Department may provide for additional payment, approximating a hospital's marginal cost of covered inpatient hospital services beyond thresholds specified by the Department. To qualify for the payment, the claim must meet the following criteria:

1) The services on the claim must be reimbursable under the DRG PPS.

 2) The DRG grouper must be able to assign the claim to a DRG.

3) The estimated claim cost for a claim exceeds the claim outlier threshold for the DRG to which the claim has been assigned.

b) Estimated Claim Cost. Estimated claim cost is based on the product of the claim total covered charges and the hospital's Medicare IPPS outlier cost-to-charge ratio. The Medicare IPPS outlier cost-to-charge ratio is determined based on:

1) For Medicare IPPS hospitals, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system hospital-specific operating and capital outlier cost-to-charge ratios effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

2) For non-Medicare IPPS hospitals, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system statewide average operating and capital outlier cost-to-charge ratios for urban hospitals for the state in which the hospital is located, effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

c) Exclusions. No outlier adjustment shall be paid on claims that are excluded from the DRG PPS pursuant to Section 149.50(b).

d) Outlier Adjustment Payment. The amount of the additional payment shall be determined as the product, rounded to the nearest hundredth, of:

1) the difference resulting from subtracting the claim outlier threshold from the estimated claim cost; and

2) the applicable SOI adjustment factor, rounded to the nearest hundredth.

e) Definitions

In addition to terms elsewhere defined in this subchapter, terms relating to outlier adjustments are defined as follows:

"Claim outlier threshold" means the sum of the DRG base payment, as defined in Section 149.100(d) and the fixed loss threshold.

"Fixed loss threshold" means the Medicare fixed loss threshold in effect on October 1, 2012. The Department is authorized to update the "fixed loss threshold". Base rates must be updated within 12 months after the update.

"MDC" means major diagnostic category.

"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.

SOI adjustment factor" means for SOI 1, 0.8000; for SOI 2, 0.8000; for SOI 3, 0.9500; for SOI 4, 0.9500.

"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMMS 1450), or one of its electronic transaction equivalents.

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)