

June 25, 2020

**ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M**

SUBJECT: HFS Proposed Rules on Reimbursement for Days beyond Medical Necessity

Senate Bill 1321 (PA 101-0209) requires Illinois Medicaid to reimburse hospitals for inpatient stays that extend beyond medical necessity due to lack of appropriate post-acute placement, effective for dates of service on or after July 1, 2019. Although the Department of Healthcare and Family Services (HFS) was to implement a payment method for these days by October 1, 2019, the proposed guidance was published just last week ([43 Ill. Reg. 10065, 10076](#)). This memorandum provides a summary of the proposed rule, outlines IHA's concerns with the guidance as currently written, and requests member feedback to inform IHA's comment letter to HFS.

Proposed Daily Reimbursement Rate

The law requires HFS to set a reimbursement rate that does not "act as an incentive" to avoid transfer to the appropriate post-acute placement or level of care needed. HFS has proposed a daily rate of \$289.48 for hospital inpatient days beyond medical necessity, which is approximately \$170 more than the average nursing home per diem; however, reimbursement would be limited to only those days for which placement in a nursing facility is not available. For DRG-reimbursed hospitals, those days that exceed the average length of stay for the assigned DRG would be eligible for reimbursement. Hospitals paid a per diem would be reimbursed for days for which inpatient care is no longer needed. Payments for these days, which HFS refers to as "Hospital Long Term Care Services," are not eligible for per diem add-on payments under the Medicaid High Volume Adjustment (MHVA) and Medicaid Percentage Adjustment (MPA) programs.

The law also requires the Managed Care Organizations (MCOs) to adhere to the reimbursement method adopted by HFS or an alternative method that pays at least as much as the fee-for-service (FFS) rate, "unless otherwise mutually agreed upon contractual language is developed by the provider and the managed care organization for a risk-based or innovate payment methodology" ([305 ILCS 5/14-13\(c\)](#)).

Proposed FFS Requirements

For the Fee-For-Service program, HFS proposes to require hospitals to obtain prior authorization by documenting at least five attempts to place the patient in appropriate settings and notifying HFS, or its contractor, of the inability to place the patient. Reimbursement will not be made for "Hospital Long Term Care Services" when the underlying inpatient acute care stay was denied by HFS as not medically necessary.

Proposed MCO Requirements

Other than the reimbursement rate, the rule is largely silent on MCOs. HFS simply refers back to the statutory language for MCO-specific requirements, which states:

For services covered by a managed care organization, hospitals shall notify the appropriate managed care organization of an admission within 24 hours of admission. For every 24-hour period beyond the initial 24 hours after admission that the hospital fails to notify the managed

care organization of the admission, reimbursement under this subsection shall be reduced by one day [305 ILCS 5/13-14(e)].

IHA's understanding is that HFS plans to address any specific requirements related to MCO implementation through contract amendments.

IHA Comments on Proposed Rule

IHA is concerned that the proposed rule does not reflect legislative intent or provide the overarching policy principles needed for HFS and the MCOs to effectively implement this mandate, particularly with respect to:

- Identification of days eligible for reimbursement provided during the retroactive period (July 1, 2019 to the effective date of the final rule) and the date by which these payments must be made to hospitals;
- The limitation on reimbursement to days where nursing facility care is not available given that patients often have other post-acute care needs;
- Conditioning payment on prior authorization rather hospital notification of its inability to place the patient (FFS) or notification of admission (MCO); and
- Lack of guidance on MCO implementation.

IHA will be submitting comments to HFS on the proposed rule to express our specific concerns and alternate approaches to implementation. To inform IHA's comment letter, members may send any feedback to IHA no later than July 3. We will share our final letter with members prior to the filing deadline in the event hospitals and health systems wish to file their own comments. Comments on the proposed rule are due to HFS by July 31.

If you have any questions please [contact IHA](#).