

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Illinois

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—  
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT**

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- 08/05 38. ALTERNATIVE REIMBURSEMENT METHODOLOGY FOR SERVICES PROVIDED BY A STATE AGENCY OR A UNIT OF LOCAL GOVERNMENT.
- a. For certain services provided by a (i) government-operated entity that is not a hospital, long term care facility, or cost-reporting clinic and (ii) government-employed (including contractually-employed) practitioners or, in the case of transportation services only, independent contractors, the State or local government agency operating that entity or employing the practitioner may elect to enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to services provided by the entity or practitioner and the funding thereof, including the certification of the expenditure of public funds by the agency in support of such services
  - b. The covered services to which this alternative methodology is available include: dental services, including dentures; clinic services; rehabilitation services; diagnostic, screening, and preventive services; case management services; home health services; podiatric services; chiropractic services; physical, occupational, and speech therapy services; audiology services; transportation services; family planning services; optometric services, including eyeglasses; Healthy Kids services; nurse midwife services; certified nurse practitioner services; and services provided by a certified local public health department.
  - c. The reimbursement rate shall be the cost incurred by the government agency, as defined in subsection (e) below and reported on the CMS approved cost report. The cost shall be computed, on a claim-by-claim basis, as the product of the provider's uniform charge for the service; multiplied by the agency-specific cost-to-charge factor for that service, as described in subsection (d) below.
  - d. The cost-to-charge factor shall be quotient of the difference of the government agency's documented expenditures for the services provided, less any funds derived from a federal funding source and any funds otherwise used as State or local match for other federal funds, divided by the total charges for services provided. The cost-to-charge factor shall be determined annually from uniform charge, expenditure, and reimbursement information reported on the CMS approved cost report and certified by the State or local government agency that operated the entity, or employed a practitioner. The certification shall be completed at the end of the agency's fiscal year. It shall be prepared and transmitted in a form and format specified by the Department, within 90 days following the end of the agency's fiscal year.
  - e. Calculation of costs. The calculation of costs shall be limited to those costs described in subsection (i) below and allocated under the requirements of subsection (ii) below as reported on the CMS approved cost report.

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- i. Allowable costs are limited to costs necessary for the delivery of a service described in subsection (b) above and include:
  - A. Payroll costs, including salaries, and benefits.
  - B. The governmental entity's cognizant agency assigned unrestricted indirect cost rate attributable to direct costs.
  - C. Direct medical supplies, materials, equipment and other costs necessary for the provision of a medical service.
  - D. Contractual costs necessary for the provision of a medical service.
- ii. Costs described in subsection (i) above shall be allocated to all benefiting programs, pursuant to the CMS approved cost report. Personnel costs will be based on certification statements showing that a provider spends 100% of their time providing direct medical services or on CMS approved time studies of personnel. A CMS approved time study is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities. All time studies must account for 100 percent of time of individuals included in the study to assure that there is no duplicate claiming. If a sample of personnel is used in a time study, the sample must be of sufficient size to ensure that the time study results will have a confidence level of at least 95% with a precision of plus or minus 5%.
- iii. Costs will be reduced by any federal funding or program income. Costs will also be reduced to the extent that the governmental entity is unable to document costs adequately.
- iv. Adjustment of claims:-
  - A. Government-operated providers reimbursed under this section may receive an ~~may~~ interim payment equal to the department's usual fee for service payment. Whether or not an interim payment is made by the department shall be defined in an intergovernmental agreement with the governmental entity. Receipt or non-receipt of an interim payment is not a condition of reimbursement under this section.
  - B. Within 180 days following the receipt, and acceptance by the department, of a certification of costs, claims will be reconciled annually to actual costs by adjusting individual claims processed through the MMIS.
  - C. Such reconciliations will be accomplished by multiplying the cost to charge ratio as described in subsection d above, by the charge on a claim.
  - D. The resulting cost will then be compared to the interim payment. If the resulting certified cost is greater than the interim rate, the claim will be adjusted up to the final reconciled cost. If the resulting cost is less than the Department's interim payment, the difference will result in a credit to the Department and will be recovered from the provider. All adjustments will take into account the receipt of any third-party payment, co-payment, or any other offsetting revenue attributable to the individual claim.