

Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #: 12-024

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



JUN 19 2014

Ms. Julie Hamos, Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

RE: Illinois State Plan Amendment (SPA) 12-024

Dear Ms. Hamos:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-024. Effective for inpatient hospital services on or after July 1, 2012, this amendment implements a payment adjustment for provider preventable conditions. This adjustment would reduce payment for inpatient hospital services by \$900 per claim and for the inpatient service if the client acquires any of the health care-acquired conditions identified by Medicare, or for any wrong surgical or other invasive procedure performed on the patient.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 12-024 is approved effective July 1, 2012. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Michelle Beasley at (312) 353-3746 or via email at Michelle.Beasley@cms.hhs.gov.

Sincerely,

A large black rectangular box redacting the signature of Cindy Mann.

Cindy Mann
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 12-024	2. STATE: ILLINOIS
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: July 1, 2012	

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)


6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 of the Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY 2012 (\$725,000) b. FFY 2013 (\$2,900,000)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Page 169	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): N/A

10. SUBJECT OF AMENDMENT:

Hospital Payments – Hospital Acquired & Provider Preventable Conditions

11. GOVERNOR'S REVIEW (Check One)


- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Theresa Eagleson 201 South Grand Avenue East Springfield, IL 62763-0001
13. TYPED NAME: Julie Hamos	
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED 9/28/12	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUN 19 2014
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PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2012	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME Penny Thompson	22. TITLE: Deputy Director, Policy + Financial Mgt. CMCS
23. REMARKS:	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Illinois

**METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT;
MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)**

07/12 **XXXIX. Payment Adjustment for Provider Preventable Conditions**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

A. Health Care –Acquired Conditions

That State identifies the following Health Care-Acquired Conditions for a reduced payment non-payment under Section 4.19(A).

- X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

The Department will deduct \$900 per claim payment and pay no outlier payment for the inpatient service if the client acquires any of the conditions identified by Medicare, regardless of any other payment methodologies as defined in this Attachment.

Effective July 1, 2014, an APR-DRG payment system will be implemented and will have the capabilities to identify Health-Care Acquired Conditions for non-payment.

B. Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections(s) 4.19-A.

- X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

 Additional Other Provider-Preventable Conditions.

In compliance with 42 CFR 447.26(c), the State provides:

- 1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
- 2) That reductions in provider payment may be limited to the extent that the following apply:
 - (a) The identified provider-preventable conditions would otherwise result in an increase in payment.
 - (b) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
- 3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.