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State/Territory Name: IL

State Plan Amendment (SPA) #: 13-003

This file contains the following documents in the order listed:

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

JUN 2 6 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) 13-003

Dear Ms. Hamos:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-003. Effective for inpatient hospital services on or after January 1, 2013, this amendment implements the potentially preventable readmission (PPR) policy. The PPR policy establishes benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications and unnecessary emergency room visits.

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 13-003 is approved effective January 1, 2013. 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,

[redacted]

Cindy Mann
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **13-003**
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: **January 1, 2013**

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] 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 2013 ($15 Million)
b. FFY 2014 ($20 Million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 15, 17, 18, 19 and 20, 20A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 15, 17, 18, 19 and 20

10. SUBJECT OF AMENDMENT:
Potentially Preventable Readmissions

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
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: [redacted]

13. TYPED NAME: **Julie Hamos**

14. TITLE: **Director of Healthcare and Family Services**

15. DATE SUBMITTED: 3/29/13

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 26 2014

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy & FINANCIAL Mgt. CMCS

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

01/13 III. Conditions for Payment Under the ~~DRG~~ Prospective Payment System

09/91 A. General Requirements

1. A hospital must meet the conditions of this Chapter to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
2. If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicaid clients, the Department may, as appropriate:
   a. Withhold Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
   b. Terminate the hospital's Provider Agreement

09/91 B. Hospital Utilization Control

10/92 Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Chapter II.C.1, shall be in accordance with Federal regulations at 42 CFR, CH. IV, Part 456, Subpart G (October 1, 1991).

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

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

D. Medical Review Requirements:

01/13

1. DRG Validation. The Department or its designee may require and perform prepayment review and/or post-payment review of specific diagnosis and procedure codes.
2. Sample Reviews.
   a. The Department, or its designee, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.
   b. Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.
3. Revision of Coding . If the diagnostic and procedural information is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding.

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09/91 E. Medical Review Requirements: The Department, or its designee, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews of:

1. The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.
2. The quality and/or nature of the utilization of health services.
3. The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Chapter V.
4. The validity of the hospital's diagnostic and procedural information.
5. The completeness, adequacy and quality of the services furnished in the hospital.
6. Other medical or other practices with respect to program participants or billing for services furnished to program participants.

Hospitals shall be notified at least thirty -(30) days in advance of any pre-admission, concurrent, or pre-payment review requirements imposed by the Department.

01/13 F. Denial or Reduction of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

1. If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:
   a. Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.
   b. Require the hospital to take action necessary to prevent or correct the inappropriate practice.
   c. Perform prepayment review in accordance with Chapter VIII.L.3.
2. When payment with respect to the discharge of an individual patient is denied by the Department, or its designee, under Section F.1.a.of this Chapter, a reconsideration will be provided within 30 days, upon the request of a practitioner or provider, if such request is the result of the designee's own medical necessity or appropriateness of care denial determination and is received within 60 days of the Advisory Notice. The date of the Advisory Notice is counted as day one.

01/13 3. A determination under Section F.1 of this Chapter, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in actions specified in Section A.2 of this Chapter.

01/13 4. Adjustments for Potentially Preventable Readmissions

For claims received on or after January 1, 2013, rates of payment to hospitals that have an excess number of potentially preventable readmissions as defined in accordance with the criteria set forth in this subsection, as determined by a risk adjusted comparison of the actual and targeted number of potentially preventable readmissions in a hospital as described below, shall be reduced as described below.

a. Potentially Preventable Readmission (PPR) Criteria.

i. A potentially preventable readmission is defined as an inpatient readmission within 30 days of discharge that is clinically related to the initial admission, as defined by the Potentially Preventable Readmission (PPR) software created and maintained by the 3M Corporation, and meets all of the following criteria:

A. The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on the 3M software, in the prior discharge or during the post discharge follow-up period.

B. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge.

C. The readmission is to the same or to any other hospital.

ii. Admissions data, for the purposes of determining PPRs, excludes the following circumstances:

A. The discharge was a patient initiated discharge and was against medical advice and the circumstances of such discharge and readmission are documented in the patient's medical record.

B. The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions, HIV, alcohol or drug detoxification, non-acute events (rehabilitation admissions), or for hospitals defined in Chapter II.C.4. with an APR DRG code other than 740 through 760.

C. The admission was for an individual who was dually eligible for Medicare and Medicaid, or was enrolled in a Managed Care Organization (MCO)

iii. Non-events are admissions to a non-acute care facility such as a nursing home or an admission to an acute care hospital for non-acute care. Nonevents are ignored and are not considered to be a readmission.

iv. Planned readmissions as defined by 3M's team of clinicians are accounted for in the 3M PPR software as an "only admission" and are not considered to be a readmission.

b. Methodology to Determine Excess Readmissions.

i. The baseline to determining any rate adjustment for State fiscal year 2013 for each hospital shall be based on each hospital's 2010 medical assistance paid claims data for admissions that occurred between July 1, 2009, and June 30, 2010.

ii. The targeted rate of readmission for each hospital shall be adjusted by the percent necessary to achieve a savings of at least $40 million in State fiscal year 2013 for hospitals other than the "large public hospitals" defined in Chapter XXI.

iii. Excess readmissions for each hospital shall be calculated by multiplying a hospital's qualifying admissions by the difference between the actual rate of PPRs and the targeted rate of PPRs. Each hospital's targeted rate is described at: www2.illinois.gov/hfs/MedicalProvider/PPRReports/Pages/default.aspx

iv. In the event the actual rate of PPRs for a hospital is lower than the targeted rate of PPRs, the excess number of readmissions shall be set at zero.

c. Payment Reduction Calculation. Hospitals with excess readmissions shall have their inpatient rates reduced in proportion to the amount of such excess readmission, as necessary to achieve annual savings of $40 million, through reduced payments or cost avoidance attributable to the hospital.

i. An average readmission payment per PPR chain for each hospital shall be calculated by dividing the total medical assistance net liability attributable to the readmissions associated with the hospital's PPR chains (excluding the liability associated with the initial admission) by the number of PPR chains for the hospital.

ii. The total excess readmission payments shall equal the average readmission payment per PPR chain, as determined in subsection c.i. above multiplied by the excess readmissions as determined in section F.4.b.iii. of this Chapter.

iii. The total annual payment reduction for each hospital shall be the total excess readmission payments as determined above not to exceed 7% of the hospitals inpatient claims payments. .

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

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

d. Definitions

"Qualifying Admission" shall mean the number of PPR chains plus the number of "Only Admissions", but specifically excludes the admissions detailed in 4.a.ii.of this section.

"Actual Rate" shall mean the number of PPR chains for a hospital divided by the total number of qualifying admissions for the hospital.

"Targeted Rate of Readmissions" shall mean a risk adjusted readmission rate for each hospital that accounts for the severity of illness, APR-DRG, presence of behavioral health issues, and age of patient at the time of discharge preceding the readmission.

10/93 G. Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1. The applicable payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non-hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in Sections G.1.b.i.through G.1.b.v. of this Chapter