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State/Territory Name: IL

State Plan Amendment (SPA) #: 14-011

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

JAN 06 2016

Felicia Norwood, 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) 14-011

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-011. Effective January 11, 2014, SNF/Ped facilities that serve exceptional care patients and have 30% or more of their patients receiving ventilator care shall receive an additional payment of $165.52 per day for ventilator care.

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 14-011 is approved effective January 11, 2014. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Fredrick Sebree, of my staff, at (217) 492-4122 or by e-mail at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
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: **14-0011**

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 11, 2014**

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 1932(a) of the *Social Security Act*

7. FEDERAL BUDGET IMPACT
a. FFY 2014 $323,750
b. FFY 2015 $450,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Page 88

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Page 88

10. SUBJECT OF AMENDMENT:
SNF/Ped – Exceptional Care Rate

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: 12/31/14

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN 06 2016

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 11 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMG

23. REMARKS:

01/14 d. Effective January 11, 2014, SNF/Ped facilities that serve exceptional care patients and have 30% or more of their patients receiving ventilator care shall receive an additional payment of $165.52 per day for ventilator care.

12. Monitoring

04/98 a. DHS/ODD shall provide for a program of delegated utilization review and quality assurance.

04/98 b. DHS/ODD shall review exceptional care residents' utilization of services at a minimum of every 90 days. A review may be waived by DHS/ODD staff if one or more previous assessments show that a resident's condition has stabilized. However, two consecutive reviews shall not be waived. DHS/ODD exceptional care staff will maintain contact with the SNF/Ped regarding the resident's condition during the time period any assessment is waived.

04/98 c. In the event that it is determined that the resident is no longer in need of or receiving exceptional care services, DHS/ODD shall discontinue the exceptional care payment rate for the resident and reduce the rate of payment to the provider to the facility's standard Medicaid per diem rate, effective the later of either the date of the review or the determination by DHS/ODD. Notice of this action shall be sent to the provider within 30 days.