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State/Territory Name: IL

State Plan Amendment (SPA) #: 15-018

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

JAN 17 2017

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) 15-018

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19C and 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-018. Effective October 1, 2015 and January 1, 2016 for the 4.19D and 4.19C pages respectively, This SPA adds language regarding minimum data set on-site reviews and language regarding payment of therapeutic bed holds for certain facilities with residents who have a TBI diagnosis.

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 15-018 is approved effective October 1, 2015 and January 1, 2016. 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 15-0018	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: Attachment 4.19-C – January 1, 2016 Attachment 4.19-D – October 1, 2015	

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 2016 – $15,000 b. FFY 2017 – $20,000 The budget impact listed above only applies to the changes to Attachment 4.19-C. The on-site reviews are budget neutral.
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-C, Page 1 Attachment 4.19-D, Pages 19-20	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-C, Page 1 Attachment 4.19-D, Pages 19-20

10. SUBJECT OF AMENDMENT:
Adds language regarding our minimum data set on-site reviews and language regarding payment of therapeutic bed holds for certain facilities with residents who have a TBI diagnosis.

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]	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
13. TYPED NAME: Felicia F. Norwood	
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JAN 17 2017
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2016 OCT 01 2015	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

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**

PAYMENT POLICY FOR RESERVING BEDS IN INPATIENT FACILITIES

~~07/12~~01/16 ~~For dates of service on or after July 1, 2012.~~ ~~a~~No bed reserve payment shall be made for persons residing in a nursing facility~~.~~, except for purposes of therapeutic home visits for individuals scoring as TBI on the MDS 3.0, beginning January 1, 2016, payment shall be approved for bed reserve days in facilities that have at least a 90% occupancy level and at least 80% of their residents are Medicaid eligible. Payment shall be at 75% of the facility's current Medicaid per diem rate and shall not exceed 10 days in a calendar month.

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

State: Illinois

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
REIMBURSEMENT TO LONG TERM CARE FACILITIES**

~~01/14~~ ~~[Reserved]~~

10/15 v. Minimum Data Set On-Site Reviews

A) The Department shall conduct reviews to determine the accuracy of the resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. The MDS data used by the Department to set the reimbursement rate will be used to conduct the validation reviews. Such reviews may, at the discretion of the Department, be conducted electronically or onsite in the facility.

B) Recalculation of Reimbursement Rate. The Department shall determine if the reported MDS data that was subsequently determined to be unverifiable would cause the direct care component of the facility's rate to be calculated differently when using the accurate data.

C) A facility's rate shall be subject to change if the recalculation of the direct care component rate, as a result of using RUGs-IV data that is verifiable:

1) Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

2) Decreases the rate by more than 10 percent in addition to the rate change specified in this section. The direct care component of the rate may be reduced, retroactive to the beginning of the rate period, by $1.00 for each whole percentage decrease in excess of 2 percent.

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

State: Illinois

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
REIMBURSEMENT TO LONG TERM CARE FACILITIES**

D) Based on the areas identified as reclassified, the nursing facility may request that the Department reconsider the assigned classification. The request for reconsideration shall be submitted in writing to the Department within 30 days after the date of the Department's notice to the facility. The request for reconsideration shall include the name and address of the facility, the name of each resident in which reconsideration is requested, the reasons for the reconsideration for each resident, and the requested classification changes for each resident based on the MDS items coded. In addition, a facility may offer explanations as to how they feel the documentation presented during the review supports their request for reconsideration. However, all documentation used to validate an area shall be submitted to the Department prior to exit. Documentation presented after exit will not be considered when determining a recalculation request. If the facility fails to provide the required information with the reconsideration request, or the request is not timely, the request shall be denied.

E) The Department shall have 120 days after the date of the request for reconsideration to make a determination and notify the facility in writing of the final decision.