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State/Territory Name: IL

State Plan Amendment (SPA) #: 16-002

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

SEP 15 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) 16-002

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-002. Effective June 1, 2016, this SPA is a revision to eligibility criteria for providers who are eligible to receive the enhanced rate for providing care to developmentally disabled clients that have high medical/high personal care needs in Intermediate Care Facilities.

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 16-002 is approved effective June 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: 16-0002
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: June 1, 2016

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 $175,600.00
b. FFY 2017 $526,805.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Page 54 and 54A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Page 54 and 54A

10. SUBJECT OF AMENDMENT:
Revision to the eligibility criteria for providers who are eligible to receive the enhanced rate for providing care to developmentally disabled clients that have high medical/high personal care needs

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: Felicia F. Norwood

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED: 6/30/16

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: SEP 15 2016

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUN 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

01/00

	16	individuals each having
x	3	medication episodes per day of
x	5	minutes per episode
	240	minutes per day
x	365	days per year
	87,600	minutes per year
÷	60	minutes per hour
	1,460	annual hours of non-nurse medication administration
÷	12	the RN supervision to non-nurse ratio
	121.67	total annual hours of RN supervision
x	$19.44	hourly RN wage factor
	$2,365.26	total annual reimbursement for all residents
÷	16	residents
÷	365	days
	$0.41	per person, per day medication administration RN supervision add-on rate

01/00 Total Program Per Diem—Total program per diem for ICF/DDs will be the sum of the amounts from Minimum staffing, Active Treatment, Specialized Care and the Related Costs and for ICFs/DD -16 (including small scale residential facilities (4 and 6 bed) ICFs/DD -16), the total program per diem shall also include Base Nursing and Supervision of Medication Administration.

11/10 5. ICFs/DD Adjustment for High Medical/High Personal Care Needs of Individuals with Developmental Disabilities

06/16 a. Qualifying Criteria - The following criteria must be met in order for ICFs/DD to receive reimbursement for residents with high medical and personal care needs.

i. Be a licensed ICFs/DD, with more than 16 licensed beds and is not:
A) An SNF/PED; or

B) A campus facility, as defined under subsection 6 of this Chapter.

ii. For the immediately preceding month, as documented in the remittance advice report, have:

A) An occupancy level of at least 93 percent of licensed ICF/DD bed capacity; and

B) At least 93 percent of the ICF/DD residents eligible for and enrolled in the Medical Assistance Program.

iii. Based on the most recently conducted annual inspection of care survey, at least 60 percent of the residents of the facility must qualify as Medical Level III.

b. Adjustment Methodology - The program and support components of the per diem rate for qualifying facilities shall be replaced with the adjusted program and support components, determined as follows:

i. Adjustment Factor - The adjustment factor for a facility shall be the product of the difference between the Medical Level III percentage and 60 percent and:

A) For facilities with a Medical Level III percentage less than 80 percent - 0.600; or

B) For all other facilities -1.700.

ii Adjusted Program Component - The adjusted program component shall equal the product of the following:

A) The program component of the per diem rate, and

B) The sum of 1.000 plus the adjustment factor for the facility, as determined above.

iii. Adjusted Support Component - The adjusted support component shall equal the SNF/PED ceiling for the geographic area in which the facility is located.

iv. Subsequent Adjustments - Adjusted program and support components shall be redetermined when:

A) Changes to the program or support rate components are required; and

B) The percentage of the residents who are classified as Medical Level III changes as a result of the facility's annual inspection of care survey. The adjusted program component shall be recalculated and effective the first day of the month following the Medical Level III determinations.

06/16

C) The percentage of residents who are classified as Medical Level III changes as a result of the facility's annual inspection of care survey. The adjusted program component shall be recalculated and effective the first day of the month following the Medical Level III determinations.

06/16

D) All high medical/high personal care rates for residents classified as Medical Level III will be reviewed and updated for changes in the facility population at least once annually upon issuance of respective facility Inspection of Care surveys.