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State/Territory Name: Illinois

State Plan Amendment (SPA) #: 20-0003

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
Division of Reimbursement Review

April 8, 2020

Theresa Eagleson, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0001

RE: State Plan Amendment (SPA) 20-0003

Dear Ms. Eagleson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 20-0003. This amendment proposes a $4,375,000 increase to provide coverage of hospital services provided due to a lack of appropriate placement.

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 implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of January, 1, 2020. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Deborah Benson at Deborah.Benson@cms.hhs.gov.

Sincerely,

Kristin Fan
Director

cc:
Deborah Benson
Fred Sebree
Courtney Savage
**Transmittal and Notice of Approval of State Plan Material**

**FOR:** Center for Medicare and Medicaid Services

**TO:** Regional Administrator

**Center for Medicare and Medicaid Services**

**Department of Health and Human Services**

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**1. Transmittal Number:**

20-U003

**2. State:**

ILLINOIS

**3. Program Identification:**

Title XIX of the Social Security Act (Medicaid)

**4. Proposed Effective Date:**

January 1, 2020

**5. Type of Plan Material (Check One):**

[ ] New State Plan  [ ] Amendment to be considered as new plan  [X] Amendment

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**6. Federal Statute/Regulation Citation:**

Section 1902 of the Social Security Act

**7. Federal Budget Impact:**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2023</td>
<td>$1.875 Million</td>
</tr>
<tr>
<td>FY 2021</td>
<td>$2.6 Million</td>
</tr>
</tbody>
</table>

**8. Page Number of the Plan Section or Attachment:**

Attachment 4.19-A, Page 110-112

**9. Page Number of the Superseded Plan Section or Attachment (If Applicable):**

Attachment 4.19-A, Page 118-112

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**10. Subject of Amendment:**

Hospital Long Term Care Days

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**11. Governor's Review (Check One):**

[ ] Governor's office reported no comment

[ ] Comments of Governor's office enclosed

[X] No reply received within 45 days of submittal

[ ] Other, as specified: Not submitted for review by prior approval

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**12. Signature of Agency Official:**

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**13. Typed Name:**

Theresa Baglow

**14. Title:**

Director of Healthcare and Family Services

**15. Date Submitted:**

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**FOR REGIONAL OFFICE USE ONLY**

**17. Date Received:**

**18. Date Approved:** 04/08/20

**19. Effective Date of Approved Material:**

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**20. Signature of Regional Official:**

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**21. Typed Name:**

Kristin Fan

**22. Title:** Director, FMG

**23. Remarks:**

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Instructions on back
XI. Hospital Long Term Care Days

01/2020  A. For dates of service on or after January 1, 2020, Hospital Long Term Care Days are days when hospital of level care is no longer necessary, but nursing facility level of care is needed and appropriate placement outside of the hospital is not available. Prior approval is required before payment can be made for these days. When the initial hospital stay is reimbursed under the DRG system, only days that exceed the DRG average length of stay can qualify as Hospital Long Term Care Days. When a hospital is reimbursed on a per diem basis, only days beyond the period of time where hospital level of care is need can qualify as Hospital Long Term Care Days.

01/2020  B. For dates of service on or after January 1, 2020, Hospital Long Term Care Days shall be reimbursed in accordance with this subsection (3). When notification to the Department of the need of post-discharge placement is required, the following requirements shall also apply:

1. The hospital must document its attempt to place the individual in at least five appropriate settings;
2. Following the five placement attempts, the hospital must notify the Department or its designated contractor of its inability to place the individual;

3. Reimbursement is limited to services prior approved and provided after the minimum number of contacts have been made and the Department or its contractor have been notified of the need for post-discharge placement. Reimbursement will not be made for services where the underlying inpatient stay was denied as not medically necessary.

C. The reimbursement rate for each eligible Hospital Long Term Care Day is $289.48 per day.

D. Payments for Hospital Long Term Care Days are not eligible for per diem add-on payments under the Medicaid High Volume Adjustment (MHVA) and Medicaid Percentage Adjustment (MPA) programs.
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)

[MATERIAL REMOVED]