Table of Contents

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

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

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,

[redacted]

Kristin Fan
Director

cc:
Deborah Benson
Fred Sebree
Courtney Savage

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: 20-0003
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, 2020

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 2020 $1.875 Million
b. FFY 2021 $2.5 Million

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 110-112

10. SUBJECT OF AMENDMENT:
Hospital Long Term Care Days

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: Theresa Eagleson

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 04/08/20

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

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

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;

01/2020 2. Following the five placement attempts, the hospital must notify the Department or its designated contractor of its inability to place the individual;

01/2020 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.

01/2020 C. The reimbursement rate for each eligible Hospital Long Term Care Day is $289.48 per day.

01/2020 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.

[MATERIAL REMOVED]