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**

~~04/07~~05/11

(C) For the purposes of calculating the rate in subsection iii(A), the annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2007, is $60 million. The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2008, is $50 million. The annul amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2009, is $84 million. The annual amount of new funds allocated for MDS reimbursement methodology beginning May 1, 2011, is $222.5 million.

E. ~~Exceptional Care and Ventilator Care~~ Reimbursement for Residents with Exceptional Needs in Nursing Facilities

10/09 1. Exceptional Care

Effective January 1, 2007, exceptional care services will be covered under the MDS-based reimbursement methodology. As long as the nursing facility's case mix, as determined by total minutes, does not decrease in excess of five percent when compared to the case mix as of June 30, 2006, exceptional care reimbursement will be converted to a per diem computed as the sum of all exceptional care daily payments less the residential rate made to the facility on June 30, 2006 divided by the total number of resident that are paid nursing and exceptional care rates as of June 30, 2006. No new residents will be accepted into the Exceptional Care Program after December 31, 2006.

10/09 2. Ventilator Care

a. Effective October 1, 2009, reimbursement to nursing facilities for ventilator dependent residents will be determined through a system separate from the Minimum Data Set (MDS) based reimbursement methodology. For purposes of this subsection, ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

01/12 b. Payment shall be made for each individual resident receiving ventilator services through the Medicaid Management Information System (MMIS). Effective January 1, 2012, t~~T~~he rate shall include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and ~~$150~~ $174 supply cost.

c. For a nursing facility to be eligible to receive ventilator service payments, the following staffing requirements must be maintained:

i. A minimum of one RN on duty on the day shift, seven days per week. Additional RN staff may be determined necessary by the Department, based on the Department's review of the ventilator services.

ii. A minimum of the required number of LPN staff on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week.

iii. A certified respiratory therapy technician or registered respiratory therapist shall be available at the facility or on call 24 hours a day.

iv. A certified respiratory therapist shall evaluate and document the respiratory status of the ventilator resident on a weekly basis.

v. At least one of the full-time licensed nursing staff members must have successfully completed a course in the care of ventilator dependent individuals and the use of ventilators, conducted and documented by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one year experience in the care of ventilator dependent persons.

10/09

vi. All staff caring for ventilator dependent residents must have documented in-service training in ventilator care prior to providing that care. In-service training must be conducted at least annually by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent persons. In-service training documentation shall include name and qualification of the in-service director, duration of presentation, content of presentation and signature and position description of all participants.

d. For a nursing facility to be eligible to receive ventilator service payments, the provider shall have and maintain physical plant adaptations to accommodate the necessary equipment, such as, an emergency electrical backup system.

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3. Traumatic Brain Injury – The following reimbursement methodology is effective for services provided January 1, 2012 and thereafter.

a. Traumatic brain injury (TBI) is a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.

b. Based on the level of functioning, according to the "Rancho Los Amigos Cognitive Scale" and the services and interventions implemented, a resident will fall into one of three tiers of payments. This payment is in lieu of any other reimbursement for nursing facility services.

c. Tier I reimbursement includes residents who have received intensive rehabilitation and are preparing for discharge to the community. The payment amount is $264.17 per day and cannot exceed six months. This tier includes residents who have received intensive rehabilitation and are preparing for discharge to the community. A resident must score a Level VIII-X on the Rancho Los Amigos Cognitive Scale, and score the following on the MDS 3.0.

i. E0300=0; no behaviors;

ii. C0500; cognitively intact;

iii. Section G; all ADL tasks coded less than 3; and

iv. Q0400A=1; active discharge in place or Q0600=1; referral has been made to local contact agency.

d. Tier II reimbursement includes residents who have reached a plateau in rehabilitation ability, but still require services related to the TBI. The payment amount is $486.49 per day and cannot exceed twelve months. This tier includes residents who have reached a plateau in rehabilitation ability, but still require services related to the TBI. A resident must score a Level IV-VII on the Rancho Los Amigos Cognitive Scale, and score the following on the MDS 3.0.

i. C0500; BIMS is less than 13 or C1000=2 or 3; cognitive skills for decision making are moderately to severely impaired;

ii. E0300=1 or E1000=1; resident has behaviors, and E0500A-C=1; these behaviors impact resident or E0600A-C=1; impact others;

iii. Section G; 3 or more ADL require extensive assistance;

iv. Two or more of the following restoratives: O0500D=1; Bed Mobility, O0500E=1; Transfer, O0500F=1; Walking, O0500G=1; Dressing/Grooming, O0500H=1; Eating or O0500J=1; Communication; and

v. O0400E2>1; Psychological or O0400F2>1; Recreational Therapy at least two or more days a week.

e. Tier III reimbursement includes acutely diagnosed residents with high rehabilitation needs. The payment amount is $767.46 per day and cannot exceed nine months. This tier includes residents with an injury resulting in a TBI diagnosis within the prior six months that are acutely diagnosed with high rehabilitation needs. A resident must score a Level IV-VII on the Rancho Los Amigos Cognitive Scale, and score the following on the MDS 3.0.

i. C0500; cognition-MMIS is less than 13 or C1000=2 or 3; cognitive skills for decision making are moderately to severely impaired;

ii. O400; Rehabilitation Therapy (OT, PT or ST) received at least 500 minutes per week and at least 1 rehab discipline 5 days a week; and

iii. O0400E2>1; Psychological Therapy at least 2 days per week.

01/12 4. Other Services for Residents with Exceptional Needs – The following reimbursement methodology is effective for services provided January 1, 2012 and thereafter.

a. Facilities scoring tracheotomy care, bariatric care, complex wound care and TBI on the MDS 2.0 shall receive an additional add-on for supply cost as determined in their daily nursing rate calculation.

b. Following are the per diem add-ons for each type of care:

i. Tracheotomy Care - $8.80

ii. Bariatric Care - $1.00

iii. Complex Wound Care - $8.80

iv. TBI - $8.80

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

08/08 Notwithstanding any other provision of this Section, the socio-development component for facilities that are classified as institutions for mental diseases shall equal 6.6% of the facility's nursing component rate as of January 1, 2006, multiplied by a factor of 3.53.

05/11 Notwithstanding the provisions set forth for maintaining rates at the levels in effect on January 18, 1994, for services beginning May 1, 2011, facilities that are federally defined as Institutions for Mental Disease (IMD) will have the nursing component of their rate calculated using the MDS methodology, and will also receive an increase to their socio-development component rate. The socio-development component rate increase will be equal to two-thirds of the difference between the highest nursing rate among the Medicaid certified IMD facilities and the individual IMD's nursing rate.

01/99 VII. Public Notice Process

01/99 The Department has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the *Social Security Act*.