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State/Territory Name: IL

State Plan Amendment (SPA) #: 14-0010

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

APR 0 8 2015

James Parker, Acting Medicaid Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

RE: Transmittal Number (TN) 14-0010

Dear Mr. Parker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under TN 14-0010. Effective for services on or after January 1, 2014, this amendment proposes to implement an evidence-based payment methodology for the reimbursement of nursing services provided in nursing facilities, using the 48-Group, Resource Utilizations Group IV classification scheme and weights published by the Centers for Medicare & Medicaid Services (CMS).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 14-0010 is approved effective January 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Fredrick Sebree at (217) 492-4122.

Sincerely,

[redacted]

Timothy Hill
Director

Enclosures

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: 14-0010
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, 2014

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 2014 $51.4 Million
b. FFY 2015 $98.5 Million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Pages 17-21 and Pages 77-80

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Pages 17-21 and Pages 77-80

10. SUBJECT OF AMENDMENT:
Nursing Home Services Reimbursement – 48 Group, RUG-IV Classification

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: Julie Hamos

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED 3-31-14

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: APR 08 2014

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME Kristin Fan

22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

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**

4. Nursing and Program Costs

a. Effective January 1, 2014, an evidence-based payment methodology will be used for the reimbursement of nursing services. The methodology takes into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Minimum Data Set (MDS), adopted and in use by the federal government.

i. This Section establishes the method and criteria used to determine the resident reimbursement classification based upon the assessments of residents in nursing facilities. Resident reimbursement classification shall be established utilizing the 48-group, Resource Utilization Groups IV (RUG-IV) classification scheme and weights as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). An Illinois specific default group is established in subsection (iii)(B) of this Section and identified as AA1 with an assigned weight equal to the weight assigned to group PA1.

ii. The statewide RUG-IV nursing base per diem rate effective on January 1, 2014, shall be $83.49.

iii. For services provided on or after January 1, 2014:

A) The Department shall compute and pay a facility-specific nursing component of the per diem rate as the arithmetic mean of the resident-specific nursing components assigned to Medicaid-enrolled residents on record, as of 30 days prior to the beginning of the rate period, in the Department's Medicaid Management Information System (MMIS), or any successor system, as present in the facility on the last day of the second quarter preceding the rate period. The RUG-IV nursing component per diem for a nursing facility shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index to be calculated quarterly, and the regional wage adjustor. Transition rates for services provided between January 1, 2014 and December 31, 2014, shall be as follows:

1) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection is greater than the nursing component rate in effect July 1, 2012, shall be paid the sum of:

a) The nursing component rate in effect July 1, 2012; plus

b) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.88.

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2) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection is less than the nursing component rate in effect July 1, 2012, shall be paid the sum of:

a) The nursing component rate in effect July 1, 2012; plus

b) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.13.

B) The Department shall determine the group to which resident is assigned using the 48-group RUG-IV classification scheme with an index maximization approach. A resident for whom RUGs resident identification information is missing, or inaccurate, or for whom there is no current MDS record for that quarter, shall be assigned to default group AA1. A resident for whom a MDS assessment does not meet the CMS edit requirements as described in the Long Term Care Resident Assessment Instrument (RAI) Users Manual or for whom a MDS assessment has not been submitted timely shall be assigned to default group AA1.

C) The assessment used for the purpose of rate calculation shall be identified as an Omnibus Budget Reconciliation Act (OBRA) assessment on the MDS following the guidance in the RAI Manual.

D) The MDS used for the purpose of rate calculation shall be determined by the Assessment Reference Date (ARD) identified on the MDS assessment.

vi. The Department shall provide each nursing facility with information that identifies the group to which each resident has been assigned.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
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~~01/07~~ ~~(5) Special minimum wage factor. The process used to determine regional mean wages for RNs, LPNs and CNAs will include a minimum wage factor. For those facilities below 90% of the statewide average, the wage is replaced by 90% of the statewide average.~~

~~01/07~~ ~~(B) Vacation, Sick Leave and Holiday Time. The time to be added for vacation, sick leave and holidays will be determined by multiplying the sum of Variable Time by 5%.~~

~~01/07~~ ~~(C) Special Supplies, Consultants and the Director of Nursing. Reimbursement will be made for health care and program supplies, consultants required by HFS (including the Medical Director) and the Director of Nursing by applying a factor to variable time and vacation, sick leave and holiday time. Supplies will be updated for inflation using the General Services Inflator. A factor for supplies will be the statewide mean of the ratio of total facility health care and programs supply costs to total facility health care and programs salaries.~~

[Reserved]

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

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

~~01/07~~ ~~The Director of Nursing and the consultants will be updated for inflation using the Nursing and Program Inflator. A factor for the Director of Nursing and consultant costs will be the statewide mean of the ratio of all facilities' Director of Nursing and consultant costs to total facility health care and programs salaries.~~

~~01/07~~ ~~iii. Beginning January 1, 2007, facilities will be paid a rate based upon the sum of the following rates identified in subsections (A) and (B):~~

~~(A) The facility MDS-based rate multiplied by the ratio the numerator of which is the quotient obtained by dividing the additional funds appropriated specifically to pay for rates based upon the MDS nursing component methodology above the December 31, 2006, funding by the total number of Medicaid patient days utilized by facilities covered by the MDS based system, and the denominator of which is the difference between the weighted mean rate obtained by the MDS based methodology, and the weighted mean rate in effect on December 31, 2006.~~

~~(B) The facility rate in effect on December 31, 2006, which is defined as the facility rate in effect on December 31, 2006, plus the exceptional care per diem computed, multiplied by one minus the ratio computed above. The exceptional care reimbursement per diem effective January 1, 2007, will be included in the nursing component of the June 30, 2006, rate unless the total variable nursing time for a rate quarter as calculated is more than a five percent drop from the total variable nursing time calculated for the June 30, 2006, rate quarter. Then the facility will receive for the rate period zero percent of the exceptional care reimbursement per diem computed.~~

[Reserved]

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

~~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 annual 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.~~

~~10/09~~ ~~(D) The ratios referenced in subsections III.C.4.a.iii.(A) and (B) shall only change annually.~~

[Reserved]

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

E. Reimbursement for Residents with Exceptional Needs in Nursing Facilities

01/14 ~~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.~~ An additional enhanced rate is applied for certain categories of residents that are in need of more resources.

01/14 ~~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~~ 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 not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices. When ventilators are used to deliver CPAP or BiPAP they shall not be counted as ventilator services for enhanced rates. Ventilator(s) set to PEEP or CPAP to aid in the weaning a resident from the ventilator are included. The weaning process shall be documented in the clinical record.

01/14 ~~01/12~~ b. An enhanced payment shall be added to the rate determined by the methodology currently in place. Payment shall be made for each individual resident receiving ventilator services, ~~through the Medicaid Management Information System (MMIS). Effective January 1, 2012, the rate shall include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and $174 supply cost.~~ For supplies and services provided on or after January 1, 2014, the rate add-on for ventilator supplies and services is $208 per day.

01/14 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~~ for 8 consecutive hours, 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~~ licensed nursing staff on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week.

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

01/14 iii. A certified respiratory therapy technician or registered respiratory therapist shall be available at the facility or on call 24 hours a day.

01/14 iv. A licensed ~~certified respiratory therapist~~ care practitioner licensed in Illinois shall be available at the facility or on call 24 hours a day. The practitioner shall evaluate and document the respiratory status of the ventilator resident on no less than 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.

~~01/1410/09~~ 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~~licensed respiratory care practitioner 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~~ title of the in-service director, duration of presentation, content of presentation and signature and position description of all participants.

01/14 vii. A pulmonologist, or physician experienced in the management of ventilator care, shall direct the care plan for ventilator residents on no less than a twice per week basis.

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.

01/14 e. The following additional criteria shall be met in order for a facility to qualify for ventilator care reimbursement.

i. A facility shall establish admission criteria to ensure the medical stability of patients prior to the transfer from an acute care setting.

ii. Facilities shall be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of the patients.

iii. Clinical assessment of oxygenation and ventilation-arterial blood gases or other methods of monitoring carbon dioxide and oxygenation shall be available on-site for management of residents.

iv. Facilities shall also be required to implement written protocols and provide documentation to support policy and procedures in the following areas:

v. Pressure ulcers, pain, immobility, risk of infection, social isolation, ventilator weaning, monitor expectations of resident, routine equipment maintenance, and staff training relating to ventilator settings and care.

vi. Documentation that the resident has a health condition that requires medical supervision 24-hours a day of licensed nursing care and specialized services or equipment.

vii. Medical records shall contain physician's orders for respiratory care that includes, but is not limited to, diagnosis, ventilator settings, tracheostomy care and suctioning, when applicable.

viii. Documentation shall support the resident receive tracheostomy care at least daily.

ix. The nursing facility shall notify the department on a designated form that includes a physician order sheet that identifies the need and delivery of ventilator services. The designated form shall also be used to notify the department when a resident is no longer receiving ventilator serves. In addition, a Section S item response of the MDS may be used.

01/14 ~~01/12~~ 3. Traumatic Brain Injury

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.

01/14

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

~~01/12~~

~~4. Other Services for Residents with Exceptional Needs~~

~~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—$1.09~~

~~iii. Complex Wound Care—$8.80~~

~~iv. TBI—$8.80~~