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State/Territory Name: IL

State Plan Amendment (SPA) #: 15-0013

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
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



February 19, 2016

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Attn: Teresa Hursey

Dear Ms. Norwood:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Transmittal #15-0013 – Elimination of the add-on payment to hospitals and freestanding chronic dialysis centers
– Effective Date: July 1, 2015

If you have any questions, please have a member of your staff contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sara Barger, HFS
Mary Doran, HFS

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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES | 1. TRANSMITTAL NUMBER 15-0013 | 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: July 1, 2015 | |

5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

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| 6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 of the Social Security Act | 7. FEDERAL BUDGET IMPACT a. FFY 2015 (\$1,875,000) b. FFY 2016 N/A |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 18.1 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Page 18.1 |

10. SUBJECT OF AMENDMENT:

Elimination of the add-on payment to hospitals and freestanding chronic dialysis centers

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
 OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:

[Redacted Signature]

13. TYPED NAME: **Felicia F. Norwood**

14. TITLE: **Director of Healthcare and Family Services**

15. DATE SUBMITTED **8/12/15**

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

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| 17. DATE RECEIVED: August 12, 2015 | 18. DATE APPROVED: February 19, 2016 |
| PLAN APPROVED—ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2015 | 20. SIGNATURE OF REGIONAL OFFICIAL: /s/ |
| 21. TYPED NAME Ruth A. Hughes | 22. TITLE: Associate Regional Administrator |
| 23. REMARKS: | |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

1.1. Reimbursement for Hospital Outpatient and Provider-Based Clinic Services Effective for Services on or after July 1, 2014.

- g. Payment for outpatient end-stage renal disease treatment (ESRDT) services shall be:
- i. At the rate established by Medicare as of December 31, 2010.
 - ii. With respect to Illinois county-owned hospitals, as defined in Chapter II.C.8. of Attachment 4.19-A, the reimbursement rate described above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
 - A. The reimbursement rates described in this section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
 - B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
 - iii. With the exception of the retrospective rate adjustment described above, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1 c.
 - iv. County-owned and State-owned hospitals shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
 - v. Effective July 1, 2013 through June 30, 2015, hospitals and freestanding chronic dialysis centers will receive an add-on payment of \$60 per treatment day to the rate described in c.i. above for outpatient renal dialysis treatments or home dialysis treatments provided to Medicaid recipients under Title XIX of the Social Security Act, excluding services provided to individuals eligible for Medicare.

07/1307/15

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient end-stage renal disease treatment services. The agency's fee schedule rate was set as of July 1, 2013 and is effective for services provided on or after that date. All rates are published on the Department's website in Practitioner Fee Schedule located at <http://www.illinois.gov/hfs/>