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State/Territory Name: IL

State Plan Amendment (SPA) #: 17-0007

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

September 11, 2017

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.

Transmittal #17-0007 – Restores Add-On Payment for Dialysis at Outpatient Hospitals and Free-Standing Centers
– Effective Date: August 5, 2017
– Approval Date: September 11, 2017

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
Kimberley Cox, HFS
Mary Doran, HFS

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: **17-0007**
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: **August 5, 2017**

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 2017 $1,250,000
b. FFY 2018 $7,500,000

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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:
Renal Rate Increase

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: **Felicia F. Norwood**

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

15. DATE SUBMITTED: 8/16/17

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: August 16, 2017

18. DATE APPROVED: September 11, 2017

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 5, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

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—
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.

07/15 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.

08/17 Effective August 5, 2017, 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.

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~~ August 5, 2017 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 www.hfs.illinois.gov/feeschedule/.