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State/Territory Name: IL

State Plan Amendment (SPA) #: 19-0001

This file contains the following documents in the order listed:

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

Financial Management Group

Theresa Eagleson, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0001

MAY 31 2019

RE: Illinois State Plan Amendment (SPA) 19-0001

Dear Ms. Eagleson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 19-0001. Effective April 1, 2019, this SPA proposes the reimbursement of an exceptional care per diem rate instead of the base rate for certain services to residents with complex or extensive medical needs in medically complex for developmentally disabled facilities.

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 regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 19-0001 is approved effective April 1, 2019. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Fredrick Sebree, of my staff, at (217) 492-4122 or by e-mail at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan,
Director

Enclosure

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 19-0001	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: April 1, 2019	

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:	7. FEDERAL BUDGET IMPACT
Section 1902 of the *Social Security Act*	a. FFY 2019 - $7,800,000 b. FFY 2020 - $15,600,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Pages 82-89B SPC SB	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, Pages 82-89A

10. SUBJECT OF AMENDMENT:
Exceptional care rates for Medically Complex for the Developmentally Disabled Facilities

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]	16. RETURN TO:
13. TYPED NAME: Theresa Eagles[redacted]	Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Mary Doran 201 South Grand Avenue East Springfield, IL 62763-0001
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED 3-6-19	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: MAY 31 2019
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2019	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*

04/19 F. Exceptional Care Program in ~~SNF/Ped Facilities~~ Medically Complex for the Developmentally Disabled Facilities

~~04/98~~04/19 1. ~~DHS/ODD~~ HFS will make payments to ~~Long Term Care for Under Age 22 Facilities, commonly referred to as SNF/Peds~~ Medically Complex for the Developmentally Disabled Facilities (MC/DD), which meet licensure and certification requirements as may be prescribed by the DPH.

~~04/98~~04/19 2. Exceptional medical care is defined as the level of care with extraordinary costs related to services, which may include nurse, ancillary specialist services, and medical equipment and/or supplies that have been determined to be a medical necessity. ~~This may apply to Medicaid clients who currently are residing in SNF/Peds, Medicaid patients who are being discharged from the hospital or other setting where Medicaid reimbursement is at a rate higher than the exceptional care rate for related services, or persons who are in need of exceptional care services and who would otherwise be in an alternative setting at a higher cost to DHS/ODD. This includes but is not limited to complex respiratory persons, ventilator dependent persons or persons with high medical needs for whom the SNF/Ped provides a cost effective living arrangement. High medical needs is defined as licensed staffing costs 50% above the level III medical add-on licensed staffing reimbursement rate.~~

~~04/98~~ ~~3. DHS/ODD shall recommend rates to DPA for their approval. DHS/ODD will calculate the rates for exceptional care service categories by using data collected from exceptional care providers.~~

~~12/95~~04/19 43. Exceptional Care Requirements

~~04/98~~04/19 a. ~~DHS/ODD~~ HFS will reimburse for exceptional care services only if the provider agrees to the following conditions:

i. The provider will maintain separate records regarding costs related to the care of the exceptional care residents.

~~04/98~~04/19 ii. The provider must meet all conditions of participation in accordance with 42 *CFR* 483 Subpart I, Conditions of Participation for Intermediate Care Facilities for ~~the Mentally Retarded~~ Individuals with Intellectual Disabilities. If the provider is not in compliance with a condition of participation and it is under appeal, ~~DHS/ODD~~ HFS will delay action on the provider's application to participate in the exceptional care program pending the outcome of the hearing.

~~04/98~~04/19

b. The provider must demonstrate the capacity and capability to provide exceptional care as documented by DPH and ~~DHS/ODD~~ HFS records, including, but not limited to, being free of Type A violations and/or conditional license brought upon by violations relating to health care services. If the Type A violation and/or conditional license is under appeal ~~DHS/ODD~~ HFS will delay action on the provider's application to participate in the exceptional care program pending the outcome of the hearing.

c. The provider must maintain and provide documentation demonstrating:

   i. Adherence to staffing requirements as set out in this part;

   ii. Adherence to staff training requirements as set out in this part;

   iii. Written agreements as required in this part;

   iv. Presence of emergency policy and procedures as set out in this part;

   v. Medical condition of the resident; and

   vi. Care, treatments and services provided to the resident.

d. When residents are mechanically supported, the provider must have and maintain physical plan adaptations to accommodate the necessary equipment; *i.e.*, emergency electrical backup system and backup ventilator available. The provider shall maintain records demonstrating the facility's maintenance of emergency equipment. Staff must be familiar with the location and operation of the emergency equipment and related procedures. To assure that staff is familiar with operating the emergency equipment, facilities must provide quarterly in-services for all staff caring for residents, including various entities affected; *i.e.*, housekeeping/infection control.

12/95 ~~5~~4. Exceptional Care Staffing Requirements

~~04/98~~04/19 a. There shall be at least one registered nurse 24 hours a day seven days per week in the facility. Based on ~~DHS/ODD's~~ HFS review of the exceptional care services needs, additional RN staff may be determined necessary by ~~DHS/ODD~~ HFS to implement the medical care plan and meet the needs of the individual.

b. There shall be at least one registered nurse or licensed practical nurse on duty at all times and on each floor housing residents (as required by DPH).

c. For those facilities providing complex respiratory or ventilator services under exceptional care, there shall be a certified respiratory therapy technician or registered respiratory therapist, on staff or on contract with the facility and on call 24 hours a day.

12/95 ~~6~~5. Training Requirements for Facilities Providing Exceptional Care for Persons with Tracheotomies and Ventilator Dependent Residents

a. At least one of the full-time professional nursing staff members has 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. A course is defined as a scheduled, structured, learning session(s) with recognition/certification of completion.

b. All staff caring for ventilator dependent residents have documented in-service training in ventilator care prior to providing such care. In-service training must be conducted at least annually by a certified respiratory therapy technician, a 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 qualifications of the in-service director, duration of presentation, content of presentation and signature and position description of all participants. The training must include care and communication with ventilator patient, proper oral care and infection control techniques including handwashing and care/cleaning of equipment.

c. All staff caring for persons with tracheotomies must have documented in-service training in tracheotomy care, other related medically complex procedures and infection control/universal precautions. The in-services should address all extraordinary situations and/or aspects of care.

~~12/95~~04/19 ~~7~~6. Exceptional Care Agreement Requirements

The provider must have a valid written agreement:

a. A medical equipment and supply provider, which must include a service contract for ventilator equipment when accepting ventilator dependent residents. Supplies include oxygen, oxygen concentrator, tracheotomy supplies and any other items needed for the services to be delivered; and

~~b. A local emergency transportation provider;~~

~~c. A hospital capable of providing the necessary care for equipment dependent residents, when appropriate; and~~

~~d~~b. A certified respiratory therapy technician or registered respiratory therapist, (unless a respiratory therapist is on staff within the facility) when accepting ventilator dependent residents or residents requiring respiratory therapy services.

12/95 ~~8~~7. Exceptional Care Emergency Policy and Procedures Requirements

The provider must have specific written policies and procedures addressing emergency needs for residents requiring exceptional care.

12/95 ~~9~~8. Accessibility to Records

~~04/98~~04/19 The provider must make accessible to ~~DHS/ODD, DPA~~HFS and/or DPH all facility, resident and other records necessary to determine the appropriateness of exceptional care services.

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

12/95 ~~10~~9. Provider Approval and Voluntary Termination Process

~~04/98~~04/19 a. A provider should notify ~~DHS/ODD~~HFS, in writing, of its interest in participating in the Exceptional Care Program.

~~04/98~~04/19 b. ~~DHS/ODD~~ HFS shall conduct a review of the facility to assure that the facility meets all the exceptional care requirements contained in this section.

~~04/98~~04/19 c. ~~DHS/ODD~~ HFS shall notify the provider in writing of its approval for exceptional care services.

~~04/98~~04/19 d. Providers desiring to discontinue providing exceptional care shall notify ~~DHS/ODD~~ HFS, in writing, at least 60 days prior to the date of termination. Payment for exceptional care residents already residing in facilities which notify ~~DHS/ODD~~ HFS that they wish to discontinue providing exceptional care services will be reduced to the facility's standard Medicaid per diem rate. ~~DHS/ODD~~ HFS will review each approved exceptional care client to determine whether he/she may remain in the facility. For the duration of the time that exceptional care clients remain in the facility, the provider must continue to meet the needs of the individual. Should a transfer to another facility be necessary, the provider must contact the responsible case-coordinating agency, which will assist in locating another provider.

~~04/98~~04/19 e. It is the responsibility of ~~an SNF/Ped~~ MC/DD provider to effect appropriate discharge planning for exceptional care residents when terminating services for exceptional care. ~~DHS/ODD agrees to assist providers with any information available regarding appropriate placement settings.~~

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**

[MATERIAL REMOVED]

~~12/95~~ ~~11. Rate Methodology~~

~~04/98~~ ~~a. A person currently residing in an SNF/Ped, or a person being discharged from a hospital or those who are in another setting must be approved by an authorized DHS/ODD representative to be eligible for exceptional care payment.~~

~~04/98~~ ~~b. Eligible items which may be used in computing the cost of the person's care include nursing services costs, therapy services costs, and medical equipment and supply costs. Computations for determining cost of care shall be based upon reasonable costs for services, medical equipment and supplies for the facility as determined by DHS/ODD.~~

~~04/98~~ ~~c. The provider must submit a request for exceptional care to DHS/ODD. An authorized DHS/ODD representative will conduct a medical review of the required care and related costs of equipment and supplies. DHS/ODD will compute the exceptional care rate as the licensed staff cost in excess of the licensed staff cost of the standard rate methodology of the medical level 3 add-on plus a related cost factor of 15% for equipment and supplies. The exceptional care rate is the licensed staff time cost in excess of the standard rate methodology at the medical level III amount once a threshold of 150% of the standard rate methodology at the medical level III is met. DHS/ODD clinical staff assesses the medical care plan of each applicant resident to determine the amount of licensed minutes of care needed. The exceptional care staff time, in minutes, which is in excess of the standard rate methodology at the medical level III is then multiplied by the geographic area licensed wage factor to obtain the exceptional care staff time rate amount. To this exceptional care staff time rate amount is added a related cost factor of 15% as specified in subsection III.C.4.b.ii(D)(1). DHS/ODD will notify the provider of the rate to be paid for the exceptional care services provided.~~

MAY 31 2019

07/1404/19 ~~12~~10. Long-term care facilities for persons under 22 years of age serving clinically complex residents.

a. Effective for dates of service on or after July 1, 2014 through March 31, 2019, long-term care facilities for persons under 22 years of age serving clinically complex residents, means facilities licensed by the Department of Public Health as a long-term care facility for persons under 22 years of age that serve severely and chronically ill pediatric patients requiring:

i. exceptional care; and

ii. have 30% or more of their patients receiving ventilator care.

b. Effective for dates of service on or after July 1, 2014 through March 31, 2019, for purposes of this Section, a person under 22 years of age, is considered clinically complex if the person requires at least one of the following medical services:

i. Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours each day.

ii. Tracheostomy care requiring suctioning at least every six hours, room air mist or oxygen as needed, and dependence on one of the treatment procedures listed under subsection iv., excluding the procedure listed in subsection iv.(A) of this Section.

iii. Total parenteral nutrition or other intravenous nutritional support and one of the treatment procedures listed under subsection iv. of this Section.

iv. The following treatment procedures apply to the conditions in subsection ii. and iii. of this Section:

(A) Intermittent suctioning at least every eight hours and room air mist or oxygen as needed.

(B) Continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent via a peripheral or central line, without continuous infusion.

(C) Peritoneal dialysis treatments requiring at least four exchanges every 24 hours.

(D) Tube feeding via nasogastric or gastrostomy tube.

(E) Other medical technologies required continuously, which in the opinion of the attending physician require the services of a professional nurse.

07/14 c. Reimbursement.

i. Effective July 1, 2014 through March 31, 2019, long-term care facilities for persons under 22 years of age serving clinically complex residents, shall receive a per diem rate of $304 for clinically complex residents.

ii. Effective July 1, 2014 through March 31, 2019, long-term care facilities for persons under 22 years of age serving clinically complex residents, that have a policy documenting their method of routine assessment of a resident's potential for being weaned from a ventilator with interventions implemented noted in the resident's record, shall receive a per diem rate of $669 for clinically complex residents on a ventilator.

~~13. Monitoring~~

~~04/98 a. DHS/ODD shall provide for a program of delegated utilization review and quality assurance.~~

~~04/98 b. DHS/ODD shall review exceptional care residents' utilization of services at a minimum of every 90 days. A review may be waived by DHS/ODD staff if one or more previous assessments show that a resident's condition has stabilized. However, two consecutive reviews shall not be waived. DHS/ODD exceptional care staff will maintain contact with the SNF/Ped regarding the resident's condition during the time period any assessment is waived.~~

~~04/98 c. In the event that it is determined that the resident is no longer in need of or receiving exceptional care services, DHS/ODD shall discontinue the exceptional care payment rate for the resident and reduce the rate of payment to the provider to the facility's standard Medicaid per diem rate, effective the later of either the date of the review or the determination by DHS/ODD. Notice of this action shall be sent to the provider within 30 days.~~

~~04/98 d. Providers shall be reviewed annually to determine whether they do/do not continue to meet all the criteria to participate in the exceptional care program. If the annual review indicates the facility does not meet the exceptional care criteria or the resident is no longer in need of or receiving exceptional care services, DHS/ODD shall terminate the agreement. Should DHS/ODD terminate the agreement, the exceptional care rate will be reduced to the facility's standard Medicaid per diem rate. Termination of the agreement shall be effective 30 days after the date of the notice. DHS/ODD will review each formerly approved exceptional care client to determine whether he/she may remain in the facility. For the duration of the time that formerly approved exceptional care clients remain in the facility, the provider must meet the needs of the individual. Should a transfer to another facility be necessary, the provider must contact the responsible case coordinating agency, which will assist in locating another provider.~~

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**

04/19

11. Exceptional Care Rate methodology for persons with complex or extensive medical needs in MC/DD Facilities

a. Effective for dates of service on or after April 1, 2019, the conditions and services used for the purposes of this Section have the same meanings as ascribed to those conditions and services under the Federal Resident Assessment Instrument (RAI) and specified in the most recent Federal manual.

b. Effective for dates of service on or after April 1, 2019, for purposes of this Section., a person is considered complex or with extensive medical needs for exceptional care if the person is receiving one of the following medical services:

i. Tier 1 is for residents who are receiving at least 51% of their caloric intake via a feeding tube.
ii. Tier 2 is for residents who are receiving tracheostomy care without a ventilator.
iii. Tier 3 is for residents who are receiving tracheostomy care and ventilator care.

c. Effective April 1, 2019, medically complex for the developmentally disabled facilities must be reimbursed an exceptional care per diem rate, instead of the base rate, for services to residents with complex or extensive medical needs. Exceptional care per diem rates must be paid for the conditions or services specified under subsection (b) at the following per diem rates: Tier 1 $326, Tier 2 $546, and Tier 3 $735.

d. Payments are subject to an adjustment if the medical documentation required in subsection 12.c. does not support the resident is receiving the medical services as specified under subsection (b). The reimbursement rate will be adjusted to the appropriate tier for services that are documented pursuant to section 12. If exceptional care services cannot be documented, the facility shall receive their base per diem rate.

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**

04/19

12. Monitoring

a. HFS shall conduct reviews to determine facility compliance as defined in this Section and to determine the accuracy of resident information and services provided as related to the specific reimbursement areas. Such reviews may, at the discretion of HFS, be conducted as a desk review or onsite in the facility.

b. The facility shall provide HFS staff with access to residents, professional and non-licensed direct care staff, facility assessors, and clinical records, as well as other documentation regarding the residents' care needs and treatments.

c. Documentation requirements

i. Supportive documentation in the clinical record shall be dated during the specified timeframe and their authors identified by signature or initials. At a minimum, the signature shall include the first initial, last name, and title/credentials. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there shall also be corresponding full identification of the initials on the same form or signature legend.

ii. Documentation in the clinical record shall consistently support service/care delivery and reflect the care related to the symptom or problem.

iii. Documentation shall support the following services/care was provided during the timeframe identified.

(A) Documentation shall support the presence of a feeding tube and the proportion of calories received through the tube feeding.

(B) Documentation shall support the presence of a tracheostomy and the tracheostomy care provided.

(C) Documentation shall support the use of a ventilator. Documentation shall support the device was an electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the person who is or who may become (such as during weaning attempts) unable to support his or her own respiration. If on a ventilator less than 16 hours a day, the facility must have documentation of active weaning. Active weaning is defined as the act or process of gradually removing residents with reversible forms of respiratory failure who are receiving mechanical ventilation from that support. This may be done by alternating full ventilator support with increasing longer periods of unassisted breathing or by alternating ventilator settings. This does not include ventilators used as Bi-level Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP) devices. devices or ventilators that is used only as a substitute for BiPAP or CPAP.

(D) Resident's assessments shall include; vitals, oxygen saturation, breath sounds and weaning potential. In addition, the assessment shall address vent settings, such as respiratory rate, fraction of inspired oxygen, tidal volume and peak inspiratory pressure.

d. All documentation that is to be considered for validation must be provided to the team prior to exit. All RAI Manual requirements and requirements identified in this subsection shall be presented to validate the identified area.

13. Appeals

a. Appeals must be submitted in writing to HFS no later than 30 days after the date of the HFS notice to the facility of the rate calculation resulting from the on-site review. The revised rate shall be processed into the payment system 30 days after the date of the HFS notice in order to allow time for submission of appeals.

b. The appeal shall contain clear and relevant supportive documentation. The facility must succinctly address the area being appealed. Additional documentation not presented to the HFS review team during the review, or at the time of exit, will not be considered in the appeal process.

c. HFS will rule on all appeals within 120 days after the date of appeal, except in rare instances where HFS may require additional information from the facility. In this case, the response period may be extended.