

EXHIBIT A

Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #: 12-018

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Companion letter & Enclosure
- 3) Summary Form (with 179-like data)
- 4) Approved SPA Pages

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



February 18, 2014

Julie Hamos, Director
Illinois Department of Healthcare and Family Services (HFS)
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: Theresa Eagleson

RE: TN 12-018

Dear Ms. Hamos:

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

Transmittal #12-018 - Approves Illinois' request to modify non-institutional payment rates as well as pharmacy reimbursement rates.

--Effective Date: July 1, 2012

If you have any questions, please have a member of your staff contact Cathy Song at (312) 353-5184 or by email at Catherine.Song1@cms.hhs.gov.

Sincerely,

/s/

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Mary Doran, HFS
Beth Green, HFS

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



February 18, 2014

Julie Hamos, Director
Illinois Department of Healthcare and Family Services (HFS)
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: Theresa Eagleson

RE: TN 12-018 Companion

Dear Ms. Hamos:

This letter is being sent as a companion to our approval of State plan amendment (SPA) 12-018 submitted September 28, 2012 by the Illinois Department of Healthcare and Family Services. This SPA proposes to modify non-institutional rates and is effective July 1, 2012. We are recommending a SPA submission to resolve our corresponding reimbursement page issues related to mental health services found on Attachment 4.19-B and identified in our companion letter to the approval of IL 12-013. The companion letter to the approval of IL 12-013 is attached to reference the issues.

The following are our companion questions and concerns for the related coverage pages under Attachment 3.1-A of State Plan for the review of IL SPA 12-018.

Appendix to Attachment 3.1-A page 8, All other adults

1. The State plan limits dental services to initial oral exams, radiographs, sedation and surgery as medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can be treated by extraction. Is the limitation on initial oral exams and radiographs based only on medical necessity? Or, are there defined limitations for these two services (i.e. one radiograph per year etc.).
2. The second bulleted item states that dental services (are covered when) medically necessary as a prerequisite for necessary medical care. It is unclear what dental services would be included under this bullet or in what circumstance this exception would be used.

The State has 90 days from the date of this letter, to address the issues described above. Within that period the State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance.

If you have any questions, please have a member of your staff contact Cathy Song at (312) 353-5184 or by email at Catherine.Song1@cms.hhs.gov.

Sincerely,

/s/

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Mary Doran, HFS
Beth Green, HFS

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



September 25, 2012

Julie Hamos, Director
Illinois Department of Healthcare & Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, IL 62763-0001

Dear Ms. Hamos:

This letter is being sent as a companion to our approval of State plan amendment (SPA) 12-013 submitted June 29, 2012 by the Illinois Department of Healthcare and Family Services. This SPA proposes to update the criteria required to be classified as a mental health professional and is effective May 1, 2012. We are recommending a SPA submission to resolve our corresponding reimbursement page issues related to mental health services found on Attachment 4.19-B and identified in this letter.

Attachment 4.19-B

For our review we identified reimbursement for mental health rehabilitative services on pages 35, 36, 40 and 41. If these are not the appropriate pages, please identify the reimbursement pages for our review.

Item 21. Mental Health Services

Section 1902(a)(30)(A) of the Act requires that states have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy and quality of care. To be comprehensive, payment methodologies should be understandable, clear and unambiguous. Since the plan is the basis for Federal Financial Participation (FFP), it is important that the plan language provide an auditable basis for determining whether payment is appropriate. The language identified for mental health services reimbursement is problematic. Items 21.a. and b. language that was approved with TN 98-014 lacks comprehensive descriptions. Some of the concerns with the language is it lacks the name of the CMS approved cost report from which costs are identified, lacks that costs are allocated according to OMB circulars and allows the State to establish new rates every year based on a formal cost methodology.

We propose a simple way to eliminate these concerns by suggesting the State submit a SPA to amend the language which identifies that the State pays for mental health services at the lesser of charge or the Medicaid maximum fee schedule. As with any SPA that changes the methodology in the State plan, this SPA submission would require appropriate public notice. Based on our review of the Illinois mental health manual, we believe you are currently using a fee schedule rate to reimburse for mental health services that are the subject of this SPA. We think the State and providers would be open to our suggested resolution of the payment issues by implementing a fee schedule consistent with rates identified in the Illinois Mental Health Billing Manual (7/11/11).

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Ms. Hamos

Based on the review of the manual pages, we have several additional recommendations for State plan changes that incorporate assurances associated with the service settings.

Services provided by Community Mental Health Agencies

1. Please provide an assurance in the State plan that services provided by community mental health agencies are not providing residential care. Our recommended language for assurance that community mental health agencies is as follows:

“the State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR 441 Subparts C and D.

The State shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or State definition of a qualified Medicaid provider.

Services provided in a Residential Facility

2. Please provide an assurance in the appropriate item of the State plan that services provided in a residential or State facility are not IMDs. We think this assurance would pertain to Community Support (residential) and Crisis Intervention State Ops and Psychosocial Rehabilitation (Facility Based). Our recommend language for this assurance is as follows:

With respect to individuals who are receiving rehabilitation services as residents of facilities the State shall not claim FFP for room and board and for non Medicaid services as a component of the rate for services authorized by this section of the State plan.

The rates in the department’s service fee schedule as authorized by this plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services such as costs associated with the cafeteria. Only those facility (direct or indirect) costs that can be identified as directly support the provision of the non-institutional services will be included in the rates.

Psychotropic Medicaid Administration

3. Please clarify if there is a billing limit for the unit of service, e.g., event. If there is a billing limit, please identify this on the State plan page or your fee schedule.

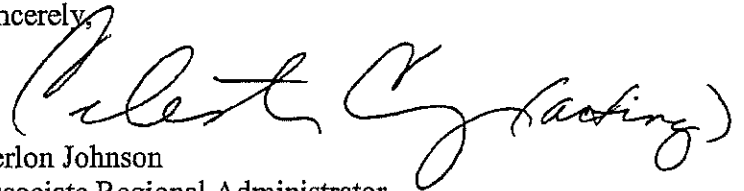
The State has 90 days from the date of this letter, to address the issues described above. Within that period the State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance.

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Ms. Hamos

If you have any questions concerning this SPA, please contact Cathy Song, of my staff, at (312) 353-5184 for more information.

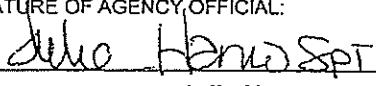
Sincerely,

A handwritten signature in black ink, appearing to read "Verlon Johnson (acting)". The signature is written in a cursive style with a large, sweeping initial "V".

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Mark McCurdy, HFS
Greg Wilson, HFS
Mary Doran, HFS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICESFORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 12-018	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, 2012	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> 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 2012 (\$696,000) b. FFY 2013 (\$2,784,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Pages 6, ⁸ 7, 9, 32, 33, 34, 34A, 35, 36 and 52, 60I	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): ⁸ Attachment 4.19-B, Pages 6, 7 9, 32, 33, 34, 34A, 35, 36 and 52	
10. SUBJECT OF AMENDMENT: Non-institutional Rate Modifications		
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Not submitted for review by prior approval.		
12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Theresa Eagleson 201 South Grand Avenue East Springfield, IL 62763-0001	
13. TYPED NAME: Julie Hamos		
14. TITLE: Director of Healthcare and Family Services		
15. DATE SUBMITTED 9/28/12		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: 9/28/12	18. DATE APPROVED: 2/18/14	
PLAN APPROVED—ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2012	20. SIGNATURE OF REGIONAL OFFICIAL: /s	
21. TYPED NAME Verlon Johnson	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

- 07/12 D. Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting which provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories: at least one hour but less than six hours and thirty-one minutes of services, at a rate of \$55 through June 30, 2002. Effective July 1, 2002, the rate is \$74; at least six hours and thirty-one minutes but less than twelve hours and thirty-one minutes of services, at a rate of \$165 through June 30, 2002. Effective July 1, 2002, the rate is \$222; or, twelve hours and thirty-one minutes of services or more at a rate of \$330 through June 30, 2002. The agency's fee schedule rate was set as of July 1, 2002 and is effective for services provided on or after that date. The rate is the lesser of the charge of \$443. Effective July 1, 2002, the rate is \$443.
- 07/02 E. Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse Type A and Type B Psychiatric Clinic Services at a rate of \$62 through June 30, 2002. Effective July 1, 2002, the rate is \$68 for Type A and \$101 for Type B services, as defined in the *Illinois Administrative Code* at 89 Ill. Adm. Code Section 148.40.d.2 and the Illinois Medicaid State Plan. A rate of \$102 will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. [Code] 149.50(c)(3) and Attachment 4.19A Chapter II.C.3 in the Illinois Medicaid State Plan. The rate for such services is based on periodic negotiations with representatives of the hospital industry.
- 07/12 F. Effective July 1, 2012, outpatient physical rehabilitation services provided by a hospital shall be reimbursed as a hospital service through the non-institutional payment system at the following rates of reimbursement:
1. The rate for rehabilitation services provided by a hospital enrolled with the Department to provide outpatient physical rehabilitation shall be \$130.00 per visit.
 2. The rate for rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation shall be \$115.00 per visit.
 3. The rate for rehabilitation services provided by children's hospitals as defined in the *Illinois Administrative Code* at 89 Ill. Adm. Code Section 149.50(c)(3) and Attachment 4.19-A Chapter II.C.3 in the Illinois Medicaid State Plan shall be \$130.00 per visit.
- 07/12 ~~Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services. Under this group, the Department will reimburse for services provided by a general care hospital not enrolled with the Department to provide outpatient physical rehabilitation services at a rate of \$115. For physical rehabilitation services provided by a hospital that is enrolled with the Department that provides specialized physical rehabilitation services the rate is \$115 through June 30, 2002. Effective July 1, 2002, the rate is \$130. The rate for such services is based on periodic negotiations with representatives of the hospital industry. A rate of \$130 will be reimbursed to children's hospitals as defined in 89 Ill. Adm. [Code] 149.50(c)(3) and Attachment 4.19A Chapter II.C.3 in the Illinois Medicaid State Plan. The rate for such services is based on periodic negotiations with representatives of the hospital industry.~~

State: Illinois STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

07/08 E. (Reserved.)

07/12 F. Reimbursement for each APL group described in subsection b.i. shall be all-inclusive for all services provided by the hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital; chemotherapy services provided in conjunction with radiation therapy services; and physical rehabilitation, occupational or speech therapy services provided in conjunction with any APL group rehabilitation services as described in subsections b.i. of this Section. For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

07/12 G. The Department of Public Aid will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered APL groups as defined in this section. ~~The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting.~~ All groups that may be reimbursed to an ASTC are defined in the Department's hospital handbook and notices to providers. Reimbursement levels shall be the lower of the ASTC's usual and customary charge to the public or an all inclusive rate for facility services, which shall be 75 percent of the applicable APL rate.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of these services. The agency's fee schedule rate was set as of July 1, 2012 and is effective for services provided on or after that date. All rates are published on the Department's website at www.hfs.illinois.gov/reimbursement.

State: Illinois

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

- 07/12 For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.
- 07/12 H. The Department of Public Aid will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered APL groups as defined in this section. The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting. All groups that may be reimbursed to an ASCT are defined in the Department's hospital handbook and notices to providers. Reimbursement levels shall be the lower of the ASTC's usual and customary charge to the public or an all inclusive rate for facility services, which shall be 75 percent of the applicable APL rate.
1. Facility services furnished by an ASTC in connection with covered APL codes include, but are not limited to:
 - a. Nursing, technician and related services;
 - b. Use of the ASTC facilities;
 - c. Supplies (such as drugs, biologicals (*e.g.*, blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of surgical procedures;
 - d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
 - e. Administrative, record keeping, and housekeeping items and services; and
 - f. Materials for anesthesia.
 2. Facility services do not include items and services for which payment may be made under other provisions of this Section such as physicians' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.
- 07/12 iii. The assignment of procedure codes to each of the reimbursement groups in subsection b.i. of this Section are identified on the agency's fee schedule. The agency's fee schedule rate was set as of July 1, 2012 and is effective for services provided on or after that date. All rates are published on the Department's website at www.hfs.illinois.gov/reimbursement. detailed in the Department's *Hospital Handbook* and in notices to providers.

State: Illinois STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

07/02 4. PRESCRIBED DRUGS:

- 07/12 a. REIMBURSEMENT. Except for Critical Clinic Providers described in Chapter 1, subsection (1)(e), pharmacies will be reimbursed for prescribed drugs at the lower of:
- i. The pharmacy's usual and customary charge to the general public.
 - ii. The applicable methodology from among the following plus the applicable dispensing fee:
 - A. Single source legend drugs. Effective July 21 ~~February 1~~, 2012, the lower of:
 - Wholesale acquisition cost of national drug code on claim, ~~plus 1%~~.
 - The State upper limit.
 - B. Multiple source legend drugs. Effective July 21 ~~February 1~~, 2012, the lower of:
 - Wholesale acquisition cost of national drug code on claim, ~~plus 1%~~.
 - The federal upper limit.
 - The State upper limit.
- 07/12 b. For multiple source legend and OTC drugs, the State upper limit reimbursement will apply to certain drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Agency. Multiple source drugs are subject to a State upper limit where the Food and Drug Administration (FDA) has rated at least two drug products pharmaceutically and therapeutically equivalent, including at least one non-innovator product. Single-source legend and OTC drugs will be subject to a State upper limit, on a case-by-case basis, where acquisition cost data demonstrates that acquisition cost is consistently and significantly lower than WAC ~~plus 1 percent~~ for a particular drug.
- 07/12 c. DISPENSING FEE: Effective July 21, ~~February 1~~, 2012, the dispensing fee shall be \$23.40 for single source drugs and \$5.506-35 for multiple source drugs. Only one dispensing fee shall be paid for each 30 day supply of drugs dispensed.
- d. CRITICAL CLINIC PROVIDERS. Reimbursement for prescribed drugs dispensed by Critical Clinic Providers shall be at the rate described in Chapter 1, subsection (1)(e)(ii) for that class of providers.
- 02/12 e. PRICING. Drug prices are updated no less frequently than monthly utilizing data procured from a national drug database source.

State: Illinois

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

5. OVER-THE-COUNTER DRUGS: Effective February 1, 2012, pharmacies will be reimbursed for over-the-counter drugs at the lower of:
- The pharmacy's usual and customary charge to the general public.
 - The wholesale acquisition cost plus 25 percent.
 - The State upper limit.
- 07/12 6. OTHER LABORATORY AND X-RAY SERVICES: Lesser of the usual and customary charge to the general public or statewide maximums established by the Department not to exceed the upper limits specified in federal regulations. Reimbursement is based upon the applicable modifier billed by the provider, and will be either for the technical component, the professional component or a global amount.
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Other Laboratory and X-ray services. The agency's fee schedule rate was set as of July 1, 2012 ~~February 1, 2010~~, 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/.
- 04-09 7. PHYSICIAN'S SERVICES: Reimbursement for physician services are at the physician's usual and customary charges, not to exceed the maximum established by the Department. Initially, maximum fee-for-service rates were established in 1978 when the Department reviewed the average charges for each of the allowable services. The Department agreed to set the statewide maximum amount at 70 percent of the average charge by physician. Annually the Department analyzes cost information and procedure code utilization of physician bills presented for Medicaid reimbursement of services rendered. The rate maximums are periodically adjusted based upon the above factors.
- 07/12 Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician services. The agency's fee schedule rate was set as of July 1, 2012 ~~April 1, 2012~~, and is effective for services provided on or after that date. All rates are published on the Department's website in the Practitioner Fee Schedule located at www.hfs.illinois.gov/feeschedule/.
- Providers, including practitioners working under the supervision of the physician and billing under the physician's name and provider number, statewide who meet the participation requirements for the Maternal and Child Health Program receive enhanced reimbursement rates for services provided to pregnant women and children through age 20 who are participants in the MCH Program. The enhanced rates, which are detailed on the practitioner fee schedule and paid in combination with the maximum fee-for-service rates, include:
- payment for performing a prenatal risk assessment (\$15);
 - payment for performing risk assessments on children (\$15);
 - increased reimbursement for deliveries (\$400 additional);
 - a \$10 increase in the EPSDT screening rate; and
 - an 8 percent increase in the reimbursement rate for office visits for children.

TN # 12-018

Approval date: 7/1^{07/14}

Effective date: 07/01/2012

Supersedes
TN # 12-11

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

8. DENTAL SERVICES: Reimbursement will be made for eligible recipients at the lesser of the usual and customary charge to the general public or statewide maximums established by the Department. The usual and customary charges are verified through post-payment audits. During these audits, private pay records are reviewed to determine the amount billed for similar procedures. If it is discovered that private pay individuals are charged less than the Medicaid population, recoupment action is taken.
- 07/12 Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Dental services. The agency's fee schedule rate was set as of July 1, 2012 ~~September 1, 2011~~, and is effective for services provided on or after that date. All rates are published on the Department's website within the Dental Office Reference Manual located at www.hfs.illinois.gov/reimbursement/dental.html.
- 07/12 9. EYEGLASSES: Same as 6. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Eyeglasses. The agency's fee schedule rate was set as of July 1, 2012 ~~February 1, 2009~~, and is effective for services provided on or after that date. All rates are published on the Department's website in the Optometric Fee Schedule located at www.hfs.illinois.gov/reimbursement/.
- 07/12 10. PODIATRIC SERVICES: Same as 6. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Podiatric services. The agency's fee schedule rate was set as of July 1, 2012 ~~April 1, 2012~~, and is effective for services provided on or after that date. All rates are published on the Department's website in the Podiatrist Procedure Code located at www.hfs.illinois.gov/reimbursement/.
- For Illinois public universities, supplemental payments are available for services provided by podiatrists employed by the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Chicago. The payments will be determined using the methodology detailed in section 7. of this attachment, as it applies to podiatric services.
- 07/12 11. CHIROPRACTIC SERVICES: Same as 6. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Chiropractic services. The agency's fee schedule rate was set as of July 1, 2012 ~~January 1, 2010~~, and is effective for services provided on or after that date. All rates are published on the Department's website in the Chiropractor fee schedule located at www.hfs.illinois.gov/reimbursement/.
- For Illinois public universities, supplemental payments are available for services provided by chiropractors employed by the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Chicago. The payments will be determined using the methodology detailed in section 7. of this attachment, as it applies to chiropractic services.
12. HOME HEALTH CARE SERVICES: Home Health Care Services rates are based on the following:
- a) Effective for services on or after July 1, 2002, home health providers shall be paid an all inclusive, per visit rate which shall be the lowest of:

State: Illinois

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

- 1) the provider's usual and customary charge to the general public for the service. The usual and customary charges are verified through post-payment audits. During these audits, private pay records are reviewed to determine the amount billed for similar procedures. If it is discovered that private pay individuals are charged less than the Medicaid population, recoupment action is taken;
 - 2) the provider's Medicare rate; or
 - 07/12 3) the Department's allowable rate of ~~\$61.34 fee schedule rate~~ set as of July 1, 2012, and effective for services provided on or after that date. All rates are published on the Department's website in Home Health Fee Schedule located at www.hfs.illinois.gov/reimbursement/.
- b) The rate methodology is uniform for governmental and private providers.

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

- 07/12 13. PRIVATE DUTY NURSING SERVICES: In-home shift nursing payments for children who are under 21 years of age shall be at the Department's established hourly rate to an agency licensed to provide these services. Prevailing community rate, subject to Department verification prior to approving charge.
- 07/12 14. INDEPENDENT SPEECH, OCCUPATIONAL AND PHYSICAL THERAPIST SERVICES: Same as 6.
15. HEALTH MAINTENANCE ORGANIZATION SERVICES: Flat monthly rate per enrolled client as established by the Department.
16. APPLIANCES/PROSTHESES: Most reasonable cost for the item which will adequately meet the client's needs. Most reasonable cost is based on the lowest of two or three estimates given prior to purchase.
- 07/12 17. MEDICAL SUPPLIES AND EQUIPMENT: Medical Supplies—Reimbursed at Department's maximum rate (cost plus 50%). Medical Equipment—Lowest price available in the geographic area where the client resides. The rate for services provided on or after July 1, 2002, shall be the rate in effect June 30, 2002, less 6 percent.
Medical Supplies: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medical Supply services. The agency's fee schedule rate was set as of July 1, 2012, and is effective for services provided on or after that date. All rates are published on the Department's website in the Medical Supplies fee schedule located at www.hfs.illinois.gov/reimbursement/.
Medical Equipment: The rate for services provided on July 1, 2012, shall be the lower of:
- The cost plus 50 percent.
 - The Medicare allowable rate less 8.7 percent.
 - The manufacturer's suggested retail price less 8.7 percent.
- 07/12 18. TRANSPORTATION: Lesser of charges or Department maximum. Ambulance, medicar service car and taxi providers: base rate plus mileage rate; oxygen add-ons may be reimbursed when provided in ambulances or medicars; attendants may be reimbursed when provided by medicars, service cars or taxis; stretchers may be reimbursed when provided by medicars; mileage may be reimbursed when provided by private automobile. Commercial carrier transportation is approved on case-by-case basis and reimbursed at the prevailing or a negotiated rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of transportation services. The agency's fee schedule rate was set as of July 1, 2012, and is effective for services provided on or after that date. All rates are published on the Department's website in the Transportation Services fee schedule located at www.hfs.illinois.gov/reimbursement/.
19. FAMILY PLANNING: Variable maximum per visit category: initial visit, annual visit, routine visit, problem visit and supply visit.
20. HEALTHY KIDS SERVICES: (Early and Periodic Screening, Diagnosis and Treatment): Variable maximum depending upon provider type: hospital outpatient clinic facility—Department approved outpatient rate; encounter rate clinic—Department approved visit rate; physician visit—Department approved rate(s).

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- 07/12 21. REHABILITATIVE SERVICES:
Mental Health Services
- a. The amount approved for payment of mental health rehabilitative services shall be based on the type and amount of service required by a client. The amount is determined in accordance with prospective rates developed by the [Department of] Human Services (DHS) or the Department of Children and Family Services (DCFS) and as adopted by the Illinois Department of Healthcare and Family Services ~~Public Aid~~ for Medicaid reimbursable services. The rates are prospective without reconciliation. The adopted rate shall not exceed the charges to the general public.
- 07/96 b. Rates are cost based and are established annually for each service. In order that costs may be determined, each provider shall submit, upon application for certification and annually thereafter, an annual audit for the prior fiscal year and two copies of the required statistical and financial information which shall be submitted on forms specified by DMHDD or DCFS. Rates will be developed through the application of formal methodologies specific to each category.
- 07/96 i. Outpatient community-based services are reimbursed at an all-inclusive per client hour rate payable to the nearest quarter hour for services actually delivered. The service hourly rate is calculated as the sum of all appropriate costs divided by available time to provide billable direct care. Appropriate costs are the sum of three components:
- A. Annual staff salary (or wages);
- B. The proportion of annual overhead costs necessary for the direct care staff person to perform duties. Overhead costs include non-salary program costs, administration, support, and occupancy/building related costs; and
- C. The annual cost of paid benefits for a direct care staff person.

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- b. Outpatient Assistance Adjustment Payments
- i. For hospitals qualifying under a.i., above the rate is \$139.00
 - ii. For hospitals qualifying under a.ii., above the rate is \$850.00.
 - iii. For hospitals qualifying under a.iii., above the rate is \$425.00.
 - 07/12 ~~12/40/09~~ iv. For hospitals qualifying under a.iv., above the rate is \$665.00, through December 31, 2014 ~~June 30, 2012~~. For dates of service on or after January 1, 2015 ~~July 1, 2012~~, the rate is \$375.00.
 - v. For hospitals qualifying under a.v., above the rate is \$250.00.
 - vi. For hospitals qualifying under a.vi., above the rate is \$336.25.
 - vii. For hospitals qualifying under a.vii., above the rate is \$110.00.
 - viii. For hospitals qualifying under a.viii., above the rate is \$200.00.
 - 07/12 ix. For hospitals qualifying under a.ix., above the rate is \$128.50, through June 30, 2010. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by \$74.00 to \$202.50. For dates of service on or after July 1, 2012 through December 31, 2014, the rate is \$247.50. For dates of service on or after January 1, 2015, the rate is \$48.50.
 - 07/12 x. For hospitals qualifying under a.x., above the rate is \$135.00. For dates of service on or after July 1, 2010 through December 31, 2014 ~~June 30, 2012~~, this rate shall be increased by \$70.00 to \$205. For dates of service on or after January 1, 2015, the rate is \$135.00
 - xi. For hospitals qualifying under a.xi., above the rate is \$65.00.
 - xii. For hospitals qualifying under a.xii., above the rate is \$90.00.
 - 12/40/09 xiii. For hospitals qualifying under a.xiii., above, that have an EMERGENCY CARE PERCENTAGE greater than 19%, but less than 25%, the rate is \$141.00. For hospitals qualifying under a.xiii., above, that have an EMERGENCY CARE PERCENTAGE greater than 25%, the rate is \$494.00.
 - 07/12 xiv. For hospitals qualifying under a.xiv., the rate is \$47.00 for dates of service on or after July 1, 2010 through December 31, 2014 ~~June 30, 2012~~. For dates of service on or after January 1, 2015 ~~July 1, 2012~~, the rate is \$0.00.

c. Payment to a Qualifying Hospital

The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by the Medicaid outpatient ambulatory procedure listing services in the OUTPATIENT ASSISTANCE ADJUSTMENT BASE YEAR. For the outpatient assistance adjustment period for fiscal year 2011 and after, total payments will equal the amount determined using the methodologies described in this subsection. The annual amount of each payment for which a hospital qualifies shall be paid, at least, quarterly.

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07/12 46. Rate Reductions

For dates of service on or after July 1, 2012, outpatient reimbursement methodologies paid to hospitals as described in this attachment shall be reduced by 3.5% for the rates that were otherwise in effect on July 1, 2012. Rate reductions defined in this chapter shall not apply to:

1. Rates or payments for hospital services delivered by a hospital defined as a safety net hospital under Section XV (K) (1) of Attachment 4.19-A.
2. Rates or payments for hospital services delivered by a hospital defined as a Critical Access Hospital that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F.
3. Rates or payments for hospital services delivered by a hospital that is operated by a unit of local government or state university that provides some or all of the non-federal share of such services.
4. Rates or payments for hospital outpatient services defined in Chapters 40 through 45 of this attachment.