**Section 146.1015 Exceptional Care Needs of Clients with Developmental Disabilities**

a) Exceptional Care Program

1) The Department of Healthcare and Family Services (Department) will make exceptional care payments to Medically Complex for the Developmentally Disabled Facilities (MC/DD) which meet licensure and certification requirements as may be prescribed by the Department of Public Health (DPH) (see the Department of Public Health's rules at 77 Ill. Adm. Code 390). A participating facility must maintain its licensure and certification and be in compliance with the applicable conditions of participation and licensing and certification standards to be eligible for exceptional care reimbursement. If DPH notifies the facility, in writing, of a need for a plan of correction for non-compliance with one or more conditions of participation, or that an imposed plan of correction for a Type A or B licensure finding is required, or if DPH notifies the facility because it has been declared an "immediate and serious threat" to the welfare of any residents, that facility will not be allowed to receive exceptional care reimbursement for any additional individuals from the date of DPH's written notification until the date DPH officially determines any and all of the conditions leading to the notification have been satisfactorily resolved. No payment for exceptional care shall be made retroactively for any residents admitted to the facility while the facility was in violation of DPH's rules at 77 Ill. Adm. Code 390. Exceptional care payment for such individuals shall commence when all such violations have been corrected, if such individuals are approved for exceptional care.

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.

b) Exceptional Care Requirements. The Department will reimburse for exceptional care services only if the MC/DD provider agrees to the following conditions:

1) The provider must maintain separate records regarding costs related to the care of the exceptional care residents.

2) The provider must meet all conditions of participation in accordance with 42 CFR 483, Subpart I, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. If the provider is not in compliance with a condition of participation and such noncompliance is under appeal, the Department will delay action on the provider's application to participate in the exceptional care program pending the official determination by DPH that any and all of the conditions leading to the noncompliance notification have been satisfactorily resolved.

3) The provider must demonstrate the capacity and capability to provide exceptional care as documented by DPH and Department records, including, but not limited to, being free of Type A violations and conditional license brought upon by violations relating to health care services. If the Type A violation or conditional license is under appeal, the Department will delay action on the provider's application to participate in the exceptional care program pending the satisfactory outcome of the action of DPH taken in regard to the facility's non-compliance with conditions of participation or the proper implementation of a plan of correction for a licensure finding. Newly licensed facilities are not immediately eligible to participate in the exceptional care program. An assessment will be made jointly by DPH and the Department to determine if the facility demonstrates the capacity and capability to provide exceptional care prior to the facility being open for 12 months. This assessment may be done prior to a facility having been open for 12 months when 15% or more licensed beds are filled with Medicaid eligible residents to present an accurate representation of the facility's ability to care for more medically involved individuals as determined by DPH.

4) For the purposes of this Section, a newly licensed facility is one that has never been licensed before, that has reopened after having discharged all residents or that has changed the focus of its operations (e.g., from ICF/SNF to ICF/DD or MC/DD). Facilities that were already participating in the Exceptional Care Program and are sold to a new licensee are not considered newly licensed.

5) The provider must maintain and provide documentation demonstrating:

A) Adherence to staffing requirements as described in subsection (c);

B) Adherence to staff training requirements as described in subsection (d);

C) Written agreements as required in subsection (e);

D) Presence of emergency policy and procedures as described in subsection (f);

E) Medical condition of the resident; and

F) Care, treatments and services provided to the resident.

6) When residents are mechanically supported, the provider must have and maintain physical plant adaptations to accommodate the necessary equipment, including an emergency electrical backup system and a 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 are familiar with operating the emergency equipment, facilities must provide quarterly in-service training for all staff caring for residents.

c) Exceptional Care Staffing Requirements

1) There shall be at least one registered nurse 24 hours a day, seven days per week in the facility. Based on the Department's review of the exceptional care services needs, additional registered nurse staff may be determined necessary by the Department to implement the medical care plan and meet the needs of the individual.

2) 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 in 77 Ill. Adm. Code 390.1040(b)).

3) 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.

4) For those facilities providing feeding tube services under exceptional care, there shall be a consultation to a Registered Dietitian for persons receiving 51% of caloric intake via a feeding tube (Tier1).

d) Training Requirements for Facilities Providing Exceptional Care for Persons with Feeding Tubes, Tracheostomies and Ventilator-Dependent Residents

1) At least one of the full-time professional 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's documented experience in the care of ventilator-dependent persons within the last three years. This nursing staff member must receive annual continuing education or in-service training on the care of ventilator-dependent individuals. This requirement may be alternatively satisfied if the facility employs on staff a certified respiratory therapy technician or registered respiratory therapist. A course is defined as a scheduled, structured, learning sessions with certification of completion.

2) All staff caring for ventilator-dependent residents must 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's 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 the proper care and cleaning of equipment.

3) All staff caring for persons with tracheostomies must have documented in-service training in tracheostomy care, other related medically complex procedures and infection control/universal precautions, prior to providing such care. In-service training documentation shall include the name and qualifications of the in-service director, duration of presentation, content of presentation and signature and position description of all participants. The in-services should address all extraordinary situations and/or aspects of care.

4) All staff caring for persons with feeding tube must have documented in-service training in care of feeding tube at least annually that includes, but is not limited to: fluid administration, medication administration, flushes, ostomy site care, infection control, and implementation of a nutrition care plan by a Registered Dietitian. In-service training documentation shall include the name and qualifications of the in-service director, duration of presentation, content of presentation and signatures and position description of all participants.

e) Exceptional Care Agreement Requirements. The provider must have a valid written agreement with:

1) 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, tracheostomy supplies and any other items needed for the services to be delivered; and

2) 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.

f) Exceptional Care Emergency Policy and Procedures Requirements. The provider must have specific written policies and procedures addressing emergency care for residents requiring exceptional care.

g) Accessibility to Records. The provider must make accessible to the Department and DPH all facility, resident and other records necessary to determine the appropriateness of exceptional care services.

h) Provider Approval and Voluntary Termination Process

1) A provider should notify the Department, in writing, of its interest in participating in the Exceptional Care Program.

2) The Department shall conduct a review of the facility to assure that the facility meets all the exceptional care requirements contained in this Section.

3) The Department shall notify the provider in writing of its approval for exceptional care services.

4) Providers desiring to discontinue provision of exceptional care shall notify the Department, in writing, at least 60 days prior to the date of termination. Payment for exceptional care residents already residing in facilities which notify the Department that they wish to discontinue providing exceptional care services will be reduced to the facility's standard Medicaid per diem rate at the time exceptional care services are discontinued. The Department will review each approved exceptional care resident to determine whether the resident may remain in the facility. For the duration of the time that exceptional care residents 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.

5) It is the responsibility of a MC/DD provider to effect appropriate discharge planning for exceptional care residents when terminating services for exceptional care.

i) Exceptional Care Rate Methodology

1) 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.

2) 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:

A) Tier 1 is for residents who are receiving at least 51% of their caloric intake via a feeding tube.

B) Tier 2 is for residents who are receiving daily tracheostomy care without a ventilator.

C) Tier 3 is for residents who are receiving daily tracheostomy care and ventilator care at least 16 hours per day.

3) Effective for dates of service on or after 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.

A) Exceptional care per diem rates must be paid for the conditions or services specified under subsection (i)(2) at the following per diem rates: Tier 1 $326, Tier 2 $546, and Tier 3 $735.

B) Effective for dates of services on or after August 1, 2019, the exceptional care per diem rate in effect on July 30, 2019 shall be increased by 3.5%.

4) Payments are subject to an adjustment if the medical documentation required in (j)(3) does not support the tier of services billed. The reimbursement rate will be adjusted to the appropriate tier for services that are documented pursuant to subsection (j). If exceptional care services cannot be documented, the facility shall receive their base per diem rate.

j) Monitoring

1) The Department 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 the Department, be conducted as a desk review or onsite in the facility.

2) The facility shall provide the Department 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.

3) Documentation requirements

A) 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 or 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.

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

C) Documentation shall support the following services or care was provided during the timeframe identified.

i) The presence of a feeding tube and the proportion of calories received through the tube feeding.

ii) The presence of a tracheostomy and the tracheostomy care provided.

iii) 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. The resident shall require at least 16 hours a day of ventilator support. If on a ventilator less than 16 hours a day, the facility must have physician orders that clearly define the weaning process and daily 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. The documentation must support the weaning process is done as ordered and must clearly document the resident's response to the weaning process on a daily basis. 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.

iv) 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.

4) 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 (i) shall be presented to validate the identified area.

k) Appeals

1) Appeals must be submitted in writing to the Department no later than 30 days after the date of the Department's 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 Department's notice in order to allow time for submission of appeals.

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

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

(Source: Added at 47 Ill. Reg. 18051, effective November 21, 2023)