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State/Territory Name: IL

State Plan Amendment (SPA) #: 07-004

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

Mr. Barry S. Maram, Director
Illinois Department of Health Care and Family Services
201 South Grand Avenue East
Springfield, Illinois 62763-0002

MAR - 3 2010

RE: Illinois 07-04

Dear Mr. Maram:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 07-04. Effective for services on or after January 1, 2007, this amendment revises methods and standards for establishing payment rates for nursing facility services. Specifically, this amendment proposes a change in determining the nursing component of the nursing facility rate with implementation of a minimum data set (MDS) based reimbursement methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 07-04 is approved effective January 1, 2007. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (608) 441-5344.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid and State Operations

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: 07-04

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: January 1, 2007

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(a) *Social Security Act*

7. FEDERAL BUDGET IMPACT
a. FFY 2007—~~$11.25~~ 24.8 million
b. FFY 2008—~~$15~~ 50.7 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 17 through 34, 77 through 81, and 100; Addendum to Attachment 4.19-D, pages 1 and 2 and Table I

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, pages 17 through 34, 77 through 81, and 100; Addendum to Attachment 4.19-D pages 1 and 2 and Table I

10. SUBJECT OF AMENDMENT:
Methods and standards for establishing payment rates for nursing facility services

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: Barry S. Maram

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Frank Kopel, Chief
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 3-3-10

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2007

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

4. Nursing and Program Costs

01/07

a. Nursing Facilities--Statewide Rates—Reimbursement for residents of nursing facilities will be based on the amount of staff time, supplies and consultant time each facility requires on the average to meet the needs of its residents in an economic and efficient manner. ~~A Resident Assessment Instrument, applied by professional IDPA Nurses,~~ The minimum data set (MDS) will be used to calculate the nursing component of the Medicaid rate. It will measure the amount of time the facility's staff uses in delivering the services needed by residents due to their varying conditions. Rates shall be determined on a statewide basis. However, the rates will vary geographically to reflect different labor cost inputs.

01/07

i. Calculation of the nursing rate.

Each Medicare and Medicaid certified nursing facility must complete and transmit quarterly to the Department, a full MDS for each resident who resides in a certified bed, regardless of payment source. The Department identified 51 MDS items that will be used to calculate a profile on each Medicaid-eligible resident within each facility. The profile for each Medicaid-eligible resident will be blended to determine the nursing component of the nursing facility's Medicaid rate.

The nursing component will be calculated annually and may be adjusted quarterly. The determination of rates will be based upon a composite of MDS data collected from each Medicaid-eligible resident who is recorded in the Department of Healthcare and Family Services' (HFS) Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the second quarter preceding the rate period. Residents for whom MDS resident identification is missing or inaccurate, or for whom there is no current MDS record for that quarter, shall be placed in the lowest MDS acuity level for calculation purposes for that quarter. The nursing component of the rate will be adjusted on a quarterly basis if any of the following conditions are met:

(A) Total variable nursing time for a rate quarter exceeds total variable nursing time calculated for the previous rate quarter by more than five percent.

(B) Total variable nursing time for a rate quarter exceeds:

(1) Total variable nursing time as calculated for the annual rate period by more than ten percent;

(2) Total variable nursing time as recalculated and adjusted for the annual period by more than five percent.

(C) Total variable nursing time for a rate quarter declines from the total variable nursing time as calculated for the annual period by more than five percent. No quarterly nursing component rate reduction will exceed five percent from the previous rate quarter.

01/07 ~~ii~~. Components of the nursing rate.

~~The rate for the nursing component will consist of the following elements: (a) reimbursement for average variable time, (b) reimbursement for fixed time, (c) reimbursement for allowable fringe benefit costs, and (d) reimbursement for allowable costs of supplies, consultants and the Medical and Nursing Directors. The analysis of these costs will be carried out annually prior to the beginning of the rate year.~~ Per diem reimbursement rates for nursing care in nursing facilities consists of three elements: variable time reimbursement, vacation, sick leave, and holiday time ~~fringe benefit~~ reimbursement, and reimbursement for supplies, consultants, medical directors and nursing directors.

01/07 (A) Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents which vary due to their physical or mental conditions. Each need level or specific nursing service measured by the ~~Resident Assessment Instrument~~ MDS is associated with an amount of time and staff level. Reimbursement is developed by multiplying the time for each service by the wage(s) of the staff (licensed or unlicensed) performing the service. If two levels of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff level. ~~When a service can be provided by either an RN or an LPN, the wage used will be weighted by the average mix of RNs and LPNs in the sample of facilities used to set rates.~~

01/07 ~~(1)~~ Determination of wages. In calculating the rate, the figure used by ~~DPA~~ HFS for "wages" will be determined in the following manner:

(1) The mean wages for the applicable staff levels (RNs, LPNs, ~~Nurses Aides~~ certified nursing assistants (CNAs) activity staff, social workers) as reported on the cost reports and determined by ~~geographical location will be the base~~ regional rate area, will be the mean wages;

09/93 (2) Payroll taxes will be calculated according to the statewide ratio of payroll taxes to total wages measured from the sample of facilities used to set rates. Effective September 1, 1993, fringe benefits will be the average percent of benefits to actual salaries of all nursing homes based upon cost reports filed.

01/07 (3) The fringe benefits, which include payroll taxes, unemployment insurance, worker's compensation, health insurance and meals, will be added to the ~~base~~ mean wage;

01/07 (4) ~~This new total~~ The mean ~~base~~ wage, including fringe benefits, will then be updated for inflation from the time period for which the wage data are available to the midpoint of the rate year to recognize projected mean ~~base~~ wage changes. ~~The wage inflation rate used to update wages will be determined by comparing the historical change in nursing home wages in Illinois between 1976 and the time the latest wage information is available to the change in the DRI average hourly earnings, production workers for nursing and personal care facilities index for the U.S. for the same period.~~

01/07

(5) Special minimum wage factor. ~~For the period beginning August 25, 1990, DPA will modify the process used in (a) above to determine regional mean wages for Registered Nurses (RN), Licensed Practical Nurses (LPN) and nurse aides to include a minimum wage factor. For those homes below 90% of the statewide average, the wage is replaced by 90% of the statewide average. Effective July 1, 1991 through June 30, 1992, a final wage multiplier of 4.1% will be applied to wages. Beginning July 1, 1992 through August 31, 1993, a final wage multiplier of 6.2% will be applied to wages. Effective September 1, 1993, the wage multiplier is eliminated.~~ The process used to determine regional mean wages for RNs, LPNs and CNAs will include a minimum wage factor. For those facilities below 90% of the Statewide average, the wage is replaced by 90% of the Statewide average.

01/07

~~(2) Determination of Times and Staff Levels. The times and staff levels have been assigned by a panel of administrators and nurses active in long term care. Prior time/motion studies were used to assist the panel. These times will be reviewed periodically to ensure that they accurately reflect nursing practice in the State.~~

01/07

~~(B) Fixed Time Reimbursement. Fixed or indirect nursing time is that time which does not vary with resident condition or which cannot be measured by an assessment tool. It includes such items as staff meetings, supervision, "downtime", checking physicians' orders and time spent with residents which do not vary with condition. For the first year, a statewide random sample of residents will be used to determine "fixed" time. The mean variable time will be computed for the sample for each level of care, and this amount subtracted from DPH Minimum Staffing Ratios plus 5% for each level of care. Once the "fixed" time has been determined, the minutes will be weighted at 20% licensed and 80% unlicensed time and multiplied by the appropriate wage. This amount will be added to variable time for each resident in the sample. If fixed time is less than zero minutes, then it will equal zero.~~

01/07

(~~C~~B) Vacation, Sick Leave and Holiday Time. The time to be added for vacation, sick leave and holidays will be determined by multiplying the sum of Variable ~~and Fixed~~ Time by 5%. ~~This time will then be weighted at 80% unlicensed and 20% licensed wages to determine the amount to be added to the rate for these benefits.~~

01/07

(~~D~~C) Special Supplies, Consultants and the Director of Nursing. ~~Finally, amounts~~ Reimbursement will be ~~added~~ made for health care and program supplies, consultants required by ~~DPH~~ HFS (including the Medical Director) and the Director of Nursing by applying a factor to variable time and vacation, sick leave and holiday time. Supplies will be updated for inflation using the General Services Inflator. ~~This amount will be determined based on the ratio of median updated supply costs by region to median costs for variable and fixed time by level of care by region.~~ A factor for supplies will be the Statewide mean of the ratio of total facility health care and programs supply costs to total facility health care and programs salaries.

01/07

The Director of Nursing and the consultants will be updated for inflation using the Nursing and Program Inflator. A factor for the Director of Nursing and consultant costs will be the Statewide mean of the ratio of all facilities' Director of Nursing and consultant costs to total facility health care and programs salaries.

01/07

~~A similar analysis will be used to determine an amount for consultants (including Medical Director) and the Director of Nursing. These costs will be updated with the nursing wage inflator.~~

01/07

~~(E) Comprehensive Patient Assessment Effective July 1, 1990, nursing facilities will be reimbursed for the new variable time service category, comprehensive patient assessment. For the reimbursement year July 1, 1990 through June 30, 1991, reimbursement of this service item will cover the period October 1, 1990 (the effective date of the new federal regulation) through June 30, 1991. Starting with July 1, 1991, the reimbursement will cover the full reimbursement year.~~

01/07

~~For the reimbursement period of July 1, 1990 until the nursing facility's first annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, the associated per diem per resident amounts of staff time and staff levels for this category of service shall be one minute of nurse aide time; 2.2 minutes of licensed nurse time; 1.4 minutes of registered nurses time; and .6 minutes of social worker time.~~

01/07

iii. Beginning January 1, 2007, facilities will be paid a rate based upon the sum of the following rates identified in subsections (A) and (B):

(A) The facility MDS-based rate multiplied by the ratio the numerator of which is the quotient obtained by dividing the additional funds appropriated specifically to pay for rates based upon the MDS nursing component methodology above the December 31, 2006, funding by the total number of Medicaid patient days utilized by facilities covered by the MDS-based system, and the denominator of which is the difference between the weighted mean rate obtained by the MDS-based methodology, and the weighted mean rate in effect on December 31, 2006.

(B) The facility rate in effect on December 31, 2006, which is defined as the facility rate in effect on December 31, 2006 plus the exceptional care per diem computed, multiplied by one minus the ratio computed above. The exceptional care reimbursement per diem effective January 1, 2007 will be included in the nursing component of the June 30, 2006 rate unless the total variable nursing time for a rate quarter as calculated is more than a five percent drop from the total variable nursing time calculated for the June 30, 2006 rate quarter. Then the facility will receive for the rate period zero percent of the exceptional care reimbursement per diem computed.

01/07

(C) For the purposes of calculating the rate in subsection iii.(A), the annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2007 is $60 million. The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2008 is $50 million. The annul amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2009 is $84 million.

01/07

~~When individual nursing facilities have their annual Inspection of Care nursing reimbursement rate update, reimbursement for this category of service will be based on individual resident need assessments from the resident assessment instrument and will be determined on an individual facility basis. The per diem per resident amounts of staff time and staff levels associated with resident assessment scores for this new category of service item which will be used in the individual facility determination of reimbursement are for base rate .5 minutes of nurse aide time; 1.1 minutes of licensed staff time; .7 minutes of registered nurse time; and .3 minutes of social worker time and for level 1, 1.5 minutes of nurse aide time; 3.3 minutes of licensed staff time; 2.1 minutes of registered nurse time; and .9 minutes of social worker time.~~

~~(F)~~ ~~Social Services~~ ~~Effective July 1, 1990, nursing facilities will be reimbursed for social services. The reimbursement of this service item will cover the nine month period from October 1, 1990 through June 30, 1991 for the reimbursement year July 1, 1990 through June 30, 1991. Starting July 1, 1991, the reimbursement will be for a full twelve month reimbursement year.~~

~~For the reimbursement period of July 1, 1990, until the nursing facility's annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, a statewide per diem reimbursement for social services will be based on the ratio of total social services wage costs to the total nursing wage costs for the facilities in the State.~~

01/07 [Reserved]

~~The actual social service and nursing wage costs facilities report in the cost reports will be used in obtaining a statewide ratio, unless the nursing facility reports no social work wage costs or the facility has 120 or more beds and it reports annualized paid and accrued social service hours of less than 2080 hours. In the case of no social service wage costs reported, the facility's data will be excluded in deriving the statewide ratio. For a facility with 120 or more beds, the social service hours to be used in deriving the wage costs will be the greater of the reported paid and accrued social service hours or the annual 2080 hour standard adjusted to the length of the facility's cost report period.~~

~~For the reimbursement period July 1, 1990 through June 30, 1991, the social service to nursing cost statewide ratio derived above will be multiplied by .75 in order to prorate the nine month per diem reimbursement amount to be paid over the full twelve months of the July 1, 1990 through June 30, 1991 reimbursement year. Effective July 1, 1991, the proration will be discontinued and the reimbursement for social services shall cover the full twelve months of the reimbursement year.~~

~~The statewide ratio will be applied to the statewide average per diem per resident nursing care time amount (staff minutes multiplied by per minute wage) obtained from the resident assessments to derive the per diem per resident social service reimbursement which shall be added to the facility's new computed nursing rate.~~

01/07 [Reserved]

~~(G) Registered Nurse Coverage Effective July 1, 1990, nursing facilities will be reimbursed for additional registered nurse coverage costs to meet the new OBRA requirements of maintaining registered nurse coverage eight hours per day seven days a week (effective October 1, 1990). The reimbursement of these additional costs will cover a nine month period for the July 1, 1990 through June 30, 1991 reimbursement year. Starting July 1, 1991, the reimbursement will cover a full twelve month period.~~

~~For the reimbursement period of July 1, 1990 until the nursing facility's annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, a statewide per diem per resident for additional RN coverage costs will be derived based on the ratio of total additional RN coverage costs to total nursing wage costs for the facilities.~~

~~If a nursing facility reports no registered nurse salary costs in the cost report and the average hourly wages for the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are less than the average hourly registered nurse (RN) wage for the region, the annual RN salary cost will be determined by multiplying an annual 2912 hour RN coverage standard by the average hourly RN wage for the region. The amount will be adjusted to the length of the facility's cost report period to obtain the additional salary costs for RN coverage. If either the DON or the ADON average hourly wages are equal to or above the average hourly RN wage for the region, the annualized DON and ADON hours paid and accrued at a wage equal to or above the average hourly RN wage will be deducted from the 2912 hour standard used in deriving the annual salary cost for RN coverage. If the balance of hours is equal to or less than zero, the facility's additional salary cost for RN coverage will be zero.~~

01/07 [Reserved]

~~If a nursing facility reports RN salary costs and the annualized paid and accrued hours are below the 2912 hour standard, the difference between the annualized paid and accrued hours and the 2912 hour standard will be determined. If either the DON or ADON average hourly wages are equal to or above the average hourly RN wage for the region, the annualized DON and ADON hours paid and accrued at a wage level equal to or above the average hourly RN wage for the region will be deducted from the hour difference. The balance of hours will be multiplied by the average hourly RN wage for the region and the product will be adjusted to the length of the facility's cost report period to obtain the facility's additional salary costs for RN coverage. If the balance of hours is equal to or less than zero, the facility's additional salary cost for RN coverage will be zero.~~

~~For the reimbursement period July 1, 1990 through June 30, 1991, the additional salary costs for RN coverage obtained above will be multiplied by .75 in order to prorate the nine month reimbursement to be paid over the full twelve months of the reimbursement year.~~

~~For the year beginning July 1, 1991, the proration will be discontinued and the reimbursement for additional RN coverage shall cover the full twelve months of the reimbursement year.~~

~~The statewide per diem reimbursement for additional RN coverage costs will be based on the ratio of the total additional RN coverage salary costs obtained from (C) above to the statewide total nursing wage costs for the facilities.~~

~~The resulting statewide ratio will be applied to the statewide average per diem per resident nursing care time cost amount (staff minutes multiplied by per minute wages) obtained from the resident assessments for the facilities to derive the statewide per diem per resident RN coverage reimbursement which shall be added to the facility's new computed nursing rate.~~

01/07 [Reserved]

~~The final additional salary costs for RN coverage obtained above shall be added to the facility's DON costs as reported in the cost report. The adjusted facility costs shall be used in determining the regional DON reimbursement ratio used to derive the DON reimbursement amount.~~

~~For facilities which have obtained a waiver of this RN coverage provision from the DPH and for facilities which do not meet the conditions described above, the additional salary costs for RN coverage will be zero. For fiscal year beginning July 1, 1992, no additional salary costs will be added for RN coverage.~~

~~ii. Determination of Nursing Rates~~

~~(A) The rate each facility receives will be determined by the assessed needs of residents the facility serves. Annually, IDPA nurses will conduct an assessment of a 100% sample of the Medicaid residents by level of care in each home. The needs of the residents in the sample will be assessed with the Resident Assessment Instrument. An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wage/wages for each assessment item, adding the appropriate amount for fixed time and amounts for vacation, sick and holiday time, supplies, consultants, and the Director of Nursing. The average of the rates for residents in the sample will become the facility's per diem reimbursement rate for each Medicaid patient in the facility for the next twelve months, at which time a new rate based on the most recent facility profile will be effective.~~

01/07 [Reserved]

~~(B) For the reimbursement period July 1, 1990 through June 30, 1991, the per diem reimbursement amounts for comprehensive patient assessment shall be calculated by multiplying the number of reimbursement staff minutes for this category of service item by the statewide average per minute staff wages and further multiplying this amount by .75 in order to prorate the nine month per diem amount to be paid over the full twelve months of the July 1, 1990 through June 30, 1991 reimbursement year.~~

~~For the reimbursement period of July 1, 1990 until the nursing facility's first annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, the prorated per diem per resident amount for comprehensive patient assessment shall be added to the facility's new computed nursing rate.~~

~~When individual facilities have their annual Inspection of Care nursing reimbursement rate update, the prorated per diem amount for comprehensive patient assessment calculated for each resident will be added to the other amounts calculated for the assessed needs of the resident and the facility rate will then be determined.~~

~~(C) The prorated per diem amount for comprehensive patient assessment calculated for each resident will be added to the other amounts calculated for the assessed needs of the resident and the facility rate will then be determined.~~

~~(D) Effective July 1, 1991, the proration of a nine month reimbursement to be reimbursed over a twelve month period will be discontinued and the reimbursement amounts for comprehensive patient assessment shall cover the full twelve months of the reimbursement year.~~

MAR - 3 2010

01/07 [Reserved]

~~A copy of the Resident Assessment will be left with the facility at the completion of each Inspection of Care.~~

~~(E) When individual nursing facilities have their annual Inspection of Care nursing reimbursement rate update through June 30, 1991, the per diem reimbursement amounts for social services, continence restorative, specialized medication monitoring, restraint management and reduction, and communication shall be calculated for each resident by multiplying the number of reimbursable staff minutes for these category of service items by the appropriate staff wages and further multiplying these amounts by .75 in order to prorate the nine month per diem amounts to be paid over a twelve month period.~~

~~The prorated per diem amounts for these new variable time category of service items calculated for each resident will be added to the other per diem amounts calculated for the assessed needs of the resident and the facility rate will then be determined.~~

~~Effective July 1, 1991, the proration of a nine month reimbursement to be reimbursed over a twelve month period will be discontinued and the reimbursement amounts for these new variable time category of service items shall cover the full twelve months of the reimbursement year.~~

~~(F) For residential nursing services provided to Medicaid residents in nursing facilities from January 1, 1989 and thereafter, DPA will determine nursing rates according to the following steps:~~

~~(1) Calculation of preliminary nursing rate: For each facility, a preliminary nursing rate will be computed according to the methods specified in subsection III.C.4.a.i.(A) through (G).~~

01/07 [Reserved]

~~(2) Calculation of the final nursing rate: For each facility, a final nursing rate will be equal to the sum of the nursing rate plus an add-on for Care Planning equal to $.45 per resident day statewide. Effective July 1, 1992 and ending August 31, 1993, there will be an additional wage adjuster add-on of $1.58 for geographic area that have wages equal to or above the statewide average and $2.00 for geographic area that have wages below the statewide average. Effective September 1, 1993, the wage adjuster add-on will be eliminated.~~

~~(G) Notwithstanding the provisions set forth for reimbursement of long term care services, effective January 18, 1994, reimbursement rates for nursing facilities will remain at the levels in effect on January 18, 1994, with the following exception:~~

~~(1) The results of Inspection of Care surveys for which the exit conference is completed prior to January 18, 1994, will be processed and reflected in facility rates effective with the annual nursing rate adjustment date.~~

~~(2) Effective for services provided on or after July 1, 1996, facilities which are located in an area which has changed geographic designation due to unique labor force factors shall have rates recalculated based upon the ceilings and norms of the newly designated geographic area.~~

01/07 [Reserved]

~~iii. Interims~~

~~(A) A facility may request an interim IOC if the following criteria has been met: a 25 percent or greater turnover in Medicaid residents since the last IOC or a sufficient reason to believe that there has been a seven percent or greater increase in the average per patient care time. Upon reassessment, an amended 2700 will be forwarded to DPA. Upon receipt of the amended 2700, the facility's rate will become effective for the final six months of that facility's rate year.~~

~~(B) For nursing facility reimbursement rates that are maintained at levels in effect on January 18, 1994, the following provisions shall be complied with when requesting an interim IOC:~~

~~(1) Rates may change based upon an interim IOC conducted at the facility's written request for any facility which changed ownership no earlier than 90 days prior to and not later than January 18, 1994. The interim IOC request must include justification and documentation which supports one of the criteria found in (A) above.~~

~~(2) Interim IOCs may be conducted, at the facility's written request, if there has been a change in the Medicaid census since the last IOC survey in accordance with subsection (A) above, except that the requirement that the request must be made within 180 days of the last IOC need not be met. The written request must contain documentation supporting the change in Medicaid census.~~

~~(3) DPA reserves the right to initiate interim IOC surveys, if necessary, based upon a significant reduction in the level of resident care or for the health and safety concerns of residents.~~

~~(4) Any rate adjustments that result from an interim IOC conducted under these provisions will have an effective date of the first day of the month following the exit date of the interim IOC.~~

01/07 [Reserved]

~~(5) Requests for interim IOC received through January 18, 1994, will be processed in accordance with (A) above.~~

~~iv. Reconsiderations~~

~~(A) A facility may request a reconsideration of the resident assessment conducted by the IOC team if the facility believes the assessment does not accurately reflect the level of need of its residents. The facility will be given the IOC assessments in batches of 20% as the Case Manager completes them for the purpose of allowing the facility time to review the assessment prior to exit conference. Differences between the facility and the IOC team regarding level of need of the residents are to be addressed using a three-step approach:~~

~~(1) Exit conference negotiation between the facility and IOC team;~~

~~(2) Central office arbitration; and~~

~~(3) First level review.~~

~~(B) At the exit conference, the facility must state the functional and service needs that it wishes to dispute. The facility is responsible for providing supporting data to the IOC team in an effort to reconcile the differences. When the differences are not reconciled through negotiation, the IOC team nurse will provide the facility appeal/ arbitration request forms on which the facility must record the level of service it believes accurately reflects the residents' needs. The nurse will automatically forward the appeal/arbitration request forms and supportive documentation provided by the facility to the central office for arbitration.~~

~~(C) Arbitration is contingent upon exit conference negotiation and the submittal of the completed appeal arbitration request forms to the IOC team.~~

~~(D) First level review is contingent upon the previous steps having been completed.~~

~~(E) Final resolution of the reconsideration process shall be within 100 days of the date of the exit conference which constitutes the first step of the process.~~

01/07 [Reserved]

~~(F) Arbitration shall be completed by nurse and/or physician arbitrators, as indicated. Any information that was not presented at the exit conference will not be considered. Results of the arbitration will be communicated in writing to the facility within 45 days after the exit conference. If the arbitration review does not resolve differences concerning disputed items to the facility's satisfaction, the facility must request, in writing, a first level review within 10 days of receipt of the central office arbitration decision. The facility can request an on-site reassessment of the residents remaining in dispute after the arbitration decision. Otherwise, the reconsideration process will be completed without advancing to first level review.~~

~~(G) First level review will be conducted by the Chief of the Bureau of Long Term Care or designee. Any information that was not presented at the exit conference, and/or the arbitration, will not be considered. The Bureau Chief or designee will reverse the arbitrator's determination only if it is demonstrated that relevant evidence was not considered or finds the arbitrator's determination against the weight of the evidence. Results of the administrator's review and reasons, therefore, will be mailed to the facility within 45 days of receipt of the facility's request for first level review.~~

~~(H) DPA reserves the right to examine the validity of all assessments. A reassessment may be conducted and will serve as the basis for the facility's program reimbursement for the rate period in question. The facility may request a review of this reassessment according to the specifications above.~~

~~Such an examination may be triggered by, but not limited to, assessments resulting in a rate increase or decrease of ten or more percent.~~

~~v. Midnight Census Report~~

~~(A) The census recorded must reflect the complete activities which took place in the 24 hour period from midnight to midnight.~~

~~(B) The facility is required to compile a midnight census report daily. The information to be contained in the report includes:~~

~~(1) Total licensed capacity.~~

~~(2) Current number of residents in house.~~

01/07 [Reserved]

~~(3) Names and disposition of residents not present in facility, i.e., therapeutic home visit, home visit, hospital (payable bedhold), hospital (nonpayable bedhold), other.~~

~~vi. Referrals~~

~~(A) Facility and/or physician referrals shall be made for each resident with a service and/or functional need unmet.~~

~~(B) A written facility response is required for each facility referral received.~~

~~(C) The facility response shall be forwarded to the Case Manager within 15 days of the IOC survey.~~

~~(D) The facility response must address categories of service and/or functional needs unmet and must address each resident's service and/or functional need unmet.~~

01/07 [Reserved]

~~vii. Quality Assurance Review~~

~~(A) Beginning July 1, 1994, quality assurance (QA) reviews will be conducted in nursing facilities to verify that programs scored during the last Inspection of Care (IOC) and new programs established for Medicaid residents continue to meet IOC criteria as described in DPA's rules.~~

~~(B) Review Process. QA reviews will include the following 11 program areas from the IOC:~~

~~(1) Restorative Bathing/Grooming~~

~~(2) Restorative Clothing~~

~~(3) Restorative Eating~~

~~(4) Restorative Mobility~~

~~(5) Restorative Continence~~

~~(6) Psychosocial/Mental Status~~

~~(7) Pressure Ulcer Treatment~~

~~(8) Pressure Ulcer Prevention~~

~~(9) Psychotropic Med Reduction~~

~~(10) Passive Range of Motion~~

~~(11) Restraint Reduction and Management~~

~~(C) A random 30 percent sample of Medicaid clients residing in a facility will be selected for the review. Wherever possible, the sample will only include residents surveyed during the last IOC. When there is not a sufficient number of residents in the facility from the last IOC to derive a random 30 percent sample, the sample will be chosen from the entire Medicaid population of the facility.~~

~~(D) There may be residents who are not receiving the same services now that they were receiving at the last IOC. Resident health status may change over time, either through improvement or deterioration, and the resident may no longer benefit from a program. Consequently, the resolution process will include a provision for scoring discontinued programs where there is documentation to support that the program was discontinued appropriately because the resident could no longer benefit from it.~~

~~(E) Notification of QA Results. Data gathered during the QA review will be evaluated by DPA.~~

~~If the results of the QA review indicate the current service level is at least 90 percent of the service level of the last IOC, the facility will pass the QA review and no further action will be taken.~~

01/07 [Reserved]

~~(F) To determine whether the 90 percent level has been maintained, DPA will compare the dollar amount calculated from the QA review for the 11 program areas to the reimbursed amount for the same 11 program areas from the latest IOC.~~

~~(G) If the QA review indicates a reduction of more than ten percent in the earned rate, the following procedures will be implemented:~~

~~(1) The facility will be notified, in writing, of the QA findings within 30 days of the QA review exit date.~~

~~(2) Upon request from the facility, consultation will be provided by DPA field staff to assist the facility with correction of problems.~~

~~(3) A follow-up QA review will be conducted between 90 and 120 days after the first QA exit date. The procedure defined in subsection (C) above will be used to select a 30 percent random sample for the follow-up QA review.~~

~~(H) The facility will be notified, in writing, of the follow-up QA findings within 30 days of the follow-up QA review exit date.~~

~~(I) If the follow-up QA review indicates a reduction of more than ten percent in earned rate from the last IOC, a full IOC on 100 percent of Medicaid residents will be initiated within 45 days of notification of the results from the follow-up QA review.~~

~~(J) Rate Adjustments. In any case where a 100 percent review is performed due to a reduction in services, rates will be recalculated and reduced, if indicated, based upon the full IOC results. The reduced rate will become effective on the first day of the month following the month that the full IOC exit took place. Rates will not be increased based upon IOC results.~~

~~(K) The QA review process will be used during the rate maintenance period which ends June 30, 1995.~~

~~(L) This Section shall be automatically repealed effective June 30, 1995.~~

E. Exceptional Care

01/07 Effective January 1, 2007, exceptional care services will be covered under the MDS-based reimbursement methodology. As long as the nursing facility's case mix, as determined by total minutes, does not decrease in excess of five percent when compared to the case mix as of June 30, 2006, exceptional care reimbursement will be converted to a per diem computed as the sum of all exceptional care daily payments less the residential rate made to the facility on June 30, 2006 divided by the total number of resident that are paid nursing and exceptional care rates as of June 30, 2006. No new residents will be accepted into the Exceptional Care Program after December 31, 2006.

01/07 ~~DPA may make payments to nursing facilities which meet licensure and certification requirements as may be prescribed by the DPH and are enrolled in and meet participation requirements of the Medical Assistance Program.~~

01/07 ~~1. Definition of Exceptional Care in Nursing Facilities~~

01/07 ~~Exceptional medical care is defined as the level of medical care with extraordinary costs related to services which include physician, nurse, ancillary specialist services and medical equipment and/or supplies that have been determined to be a medical necessity. This shall apply to 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 to persons who are in need of exceptional care services who would otherwise be in an alternative setting at a higher cost to DPA or Medicaid eligible residents transitioning from Medicare to Medicaid while in the nursing facility. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or related condition, head injured persons and ventilator dependent persons.~~

01/07 ~~2. Description of Related Factors Necessary for Admission of Exceptional Care Clients~~

01/07 ~~a. The nursing facility must agree to all provisions of the agreement. Criteria regarding the provider's ability to provide exceptional care includes, but is not limited to:~~

01/07 ~~i. Demonstration of ability to provide specialized nursing care as documented by DPH and DPA records, specifically a minimum of one RN on duty day shift seven days per week. Additional RN staff may be determined necessary by DPA, based on DPA's review of the individual exceptional care clients' needs. A minimum required number of LPN staff on duty with an RN on call at night; and a respiratory therapist on contract if serving ventilator dependent residents or residents requiring respiratory therapy services;~~

01/07 [Reserved]

~~ii. Documentation of specialized training and inservicing of all staff caring for exceptional care residents;~~

~~b. Physical plan adaptations to accommodate the necessary equipment, such as an emergency electrical backup system;~~

~~i. Appropriate policies and procedures to address the specific needs of the exceptional care resident, including emergency needs;~~

~~ii. Valid written agreements for the provision of all necessary medical equipment and supplies, and special services such as respiratory therapy.~~

~~c. Information from IDPH and IDPA records will be reviewed and an on-site assessment will be conducted by IDPA Exceptional Care staff as part of determining a facility's ability to provide exceptional care services.~~

~~3. Provider Approval Process and Payment~~

~~a. A provider shall notify DPA, in writing, of its interest in participating in the Exceptional Care Program.~~

01/07 [Reserved]

~~b. DPA shall negotiate rates with facilities requesting payment for exceptional care services. In determining the rates of payment, DPA shall consider data collected from exceptional care providers during fiscal year 1994, any intervening rate adjustments (including any updates for inflation) and the average cost of each service category for the geographic area in which the facility is located. After approval of negotiated rates, DPA shall annually update a facility's rate for inflation. The rate of payment will be reasonable and adequate to meet the costs incurred by the facilities providing exceptional care. The rate of payment shall not exceed the amount DPA determines would be paid under Medicare principles of reimbursement.~~

~~c. In order for a person to be approved for exceptional care placement, the cost of the person's care must be at least 50 percent more than the proposed admitting provider's Medicaid per diem rate (capital, support and nursing components). Computations for determining cost of care shall be based upon costs for services, medical equipment and supplies for the proposed admitting provider as determined by DPA.~~

01/07 [Reserved]

~~d. If approved by DPA, a written exceptional care agreement with the provider shall be executed.~~

~~4. Exceptional Care Monitoring~~

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

~~b. DPA shall provide for a program of delegated utilization review and quality assurance. The Department DPA may contract with Medical Peer Review organizations to provide utilization review and quality assurance.~~

~~c. DPA shall review exceptional care residents' utilization of services every ninety (90) days. A review may be waived by the Department DPA if one or more previous assessments show that a resident's condition has stabilized. However, two consecutive reviews shall not be waived. Department DPA exceptional care staff will maintain contact with the long term care provider regarding the resident's condition during the time period any assessment is waived.~~

~~5. Termination of Exceptional Care Services~~

~~a. Providers desiring to discontinue providing exceptional care shall notify DPA, in writing, at least 60 days prior to the date of termination. Payment for exceptional care residents already residing in facilities which notify DPA that they wish to discontinue providing exceptional care services will remain at the previous exceptional care rate as long as the resident meets exceptional care criteria and as long as all related criteria are met by the provider as determined by DPA's utilization review or the resident is discharged.~~

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01/07 [Reserved]

~~b. It is the responsibility of the provider to effect appropriate discharge planning for exceptional care residents when terminating services for exceptional care. DPA agrees to assist providers with any information available regarding appropriate placement settings.~~

~~c. DPA may terminate a provider's agreement, for any reason, upon 60 days written notice to the provider. Reasons for which DPA may terminate an agreement include, but are not limited to, DPH findings that the provider has deficiencies related to substandard quality of care or imposition of a conditional license.~~

01/07

(C) Specialized Care— An amount will be paid for clients who are in need of Specialized Care for Behavior Development Programs and/or Health and Sensory Disabilities. Specialized care refers to care needed by some individuals to attain their greatest possible levels of behavioral and/or physical health and development. Identification and validation of an individual's need for either or both categories of Specialized Care will be made during the annual IOC of the ICF/MR~~, or nursing facility~~ where the individual resides.

(1) In each category of Specialized Care, there are three levels of services. The service level for each client meeting the criteria of more than one service level in a category of Specialized Care will be determined according to the one level which will result in the greatest reimbursement amount. Reimbursement for the three levels is determined on the basis of:

a) Level 1— .50 hours of Direct Service per service day.

b) Level II— 1.0 hours of Direct Service per service day.

c) Level III— 2.0 hours of Direct Service per service day.

Reimbursement for clients who qualify for Level III in the category of Health and Sensory Disabilities is also made for 3.0 hours of licensed nurse time, at a ratio of 1:30 per service day.

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**

01/07 ~~The total cost estimate for the OBRA related areas is based on projected statewide utilization of the six IOC services, the allowable staff times for each area, and the statewide average wages paid by nursing facilities and updated to the current rate year. These data are utilized to obtain the statewide average estimated per diem per resident increased staffing costs to facilities for each of the six IOC areas. These costs estimates are detailed in Table I. The costs to individual facilities will vary according to their individual utilization levels for the six IOC services and the staff wages in their geographic region. Allowable staffing types and times for each of the six IOC areas are standard across the state and do not contribute to variation in facility-specific costs.~~

~~The statewide average estimated per diem per resident staffing cost is $2.68 for all six OBRA related areas of the IOC which includes additional related costs of consultant and director of nursing services and of health care/program supplies. The final statewide average estimated per diem per resident rate for the six OBRA related areas of the IOC is $2.78 for FY'99. This per diem amount was multiplied by the estimated Medicaid patient care days for FY'99 to obtain the total estimated annual costs of $62.5 million to be incurred by facilities for the six OBRA related IOC areas.~~

~~Continuing Education for Nurse Aides. Increased costs resulting from nurse aide staff time for on the job training in the OBRA related IOC areas are built into the staff times assigned to these IOC areas. Increased costs for registered nurse or licensed practical nurse supervisors to train nurse aides in these IOC areas are built into the assigned staff times as well. Since the largest portion of the allocation for nurse aide training costs is built into the staffing times for each of the IOC areas, the Department has no means of itemizing these specific costs.~~

~~Nurse Staffing Requirements. Increased costs to facilities for registered nurse, licensed practical nursing and nurse aide staffing requirements are accounted for in the staff times allowed for each OBRA-related IOC area.~~

~~Other Staffing Requirements. Increased staffing costs for social workers to serve as part of the multi-disciplinary resident assessment team and to coordinate the OBRA related social services are accounted for in the social worker staff time under these two IOC areas.~~

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

01/07 ~~The OBRA-related specialized medications service--management of psychotropic drugs--requires the involvement of a pharmacist. Pharmacy services of filling a prescription are ancillary services under the Illinois Group Care Medicaid reimbursement system and are paid for on a fee-for-service basis directly to the pharmacy provider. Nursing facilities will not incur any increased costs in meeting this provision as it relates to filling prescriptions for psychotropic drugs. However, nursing facilities will incur increased costs for pharmacist consultation services in planning the management of psychotropic drugs for individual residents.~~

~~There are no new requirements which will result in increased costs to facilities for dietician, dental, medical records, activity staff or other staff services.~~

~~Resident Assessments. Increased costs incurred by facilities for registered nurse coordinated multi-disciplinary focused comprehensive resident assessments using the MDS are accounted for under the OBRA related IOC comprehensive resident assessment service area. Staffing types and times for the base level of this IOC service were determined by an internal expert panel on the basis of the minimum requirement of one resident assessment and quarterly reviews annually. The staffing types and times for the second level were established based on a resident's need for more frequent assessments and reviews.~~

~~Plans of Care. No changes in the Departments provisions regarding patient care planning were necessary under the new OBRA requirements, therefore, facilities will not incur any increased costs for these OBRA requirements.~~

~~Resident Personal Funds. Changes in the Department's provisions regarding management of patients' funds under the new OBRA requirements did not necessitate any increased costs on the part of nursing facilities.~~

~~Resident Rights. Increased costs incurred by facilities for the provision of resident rights services are accounted for under the OBRA-related IOC social services area. Staffing types and times for this service were determined by an internal expert panel on the basis of the extent and level of the resident rights and resident and family participation services covered under this IOC area.~~

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**

01/07

~~**Table I**~~

~~**Fiscal Year (FY) 1999**~~
~~**OBRA FINDINGS**~~

~~OBRA IOC Area~~	~~Levels~~	~~(1) 9/94 $/score~~	~~(2) January FY 97 $/score~~	~~(3) FY 99 $/score~~	~~(4) FY 99 Estimated Util %~~	~~(5) FY 99 Weighted Rate~~	~~(6) FY 98 Actual Cost~~	~~(7) FY 99 Inflated Costs~~	~~(8) FY 99 Weighted Costs~~
~~Comprehensive Resident Assessment~~	~~0~~	~~0.78~~	~~0.83~~	~~0.83~~	~~0.87~~	~~0.73~~	~~0.75~~	~~0.78~~	~~0.68~~
	~~1~~	~~2.35~~	~~2.51~~	~~2.51~~	~~0.13~~	~~0.32~~	~~2.24~~	~~2.33~~	~~0.29~~
~~Communication~~	~~0~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.91~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.00~~
	~~1~~	~~0.48~~	~~0.51~~	~~0.51~~	~~0.08~~	~~0.04~~	~~0.49~~	~~0.51~~	~~0.04~~
	~~2~~	~~0.97~~	~~1.04~~	~~1.04~~	~~0.01~~	~~0.01~~	~~0.98~~	~~1.02~~	~~0.01~~
	~~3~~	~~1.45~~	~~1.55~~	~~1.55~~	~~0.00~~	~~0.00~~	~~1.47~~	~~1.53~~	~~0.00~~
~~Restraint Reduction~~	~~0~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.87~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.00~~
	~~1~~	~~1.94~~	~~2.07~~	~~2.07~~	~~0.13~~	~~0.27~~	~~1.97~~	~~2.05~~	~~0.26~~
~~Social Services~~	~~0~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.01~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.00~~
	~~1~~	~~0.45~~	~~0.48~~	~~0.48~~	~~0.56~~	~~0.27~~	~~0.45~~	~~0.47~~	~~0.26~~
	~~2~~	~~1.49~~	~~1.59~~	~~1.59~~	~~0.43~~	~~0.69~~	~~1.55~~	~~1.61~~	~~0.70~~
~~Specialized Medication~~	~~2~~	~~1.75~~	~~1.87~~	~~1.87~~	~~0.21~~	~~0.40~~	~~1.65~~	~~1.72~~	~~0.36~~
~~Continence Restorative~~	~~0~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.98~~	~~0.00~~	~~0.00~~	~~0.00~~	~~0.00~~
	~~1~~	~~2.58~~	~~2.76~~	~~2.76~~	~~0.02~~	~~0.04~~	~~2.64~~	~~2.75~~	~~0.04~~
	~~2~~	~~4.50~~	~~4.81~~	~~4.81~~	~~0.00~~	~~0.02~~	~~4.66~~	~~4.85~~	~~0.02~~
				~~**Total Rate: 2.78**~~				~~**Total Costs: 2.68**~~	

~~(1) The rate for each OBRA item for September of 1993. This rate was frozen until January 1, 1997.~~

~~(2) The January 1, 1997, rate which is 6.8% over the September of 1993 rate.~~

~~(3) The FY'99 rate is assumed at this time to be frozen at the January 1997 rate.~~

~~(4) With the rate freeze assumption, FY'97 utilization is FY'99 estimate.~~

~~(5) The FY'99 rate.~~

~~(6) The OBRA staff model times FY'98 wages.~~

~~(7) The FY'98 costs inflated based on DRI.~~

~~(8) The FY'99 cost.~~

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