II. Allowable Costs

A. Allowable costs include reasonable costs of meeting licensure and certification requirements including the provision of services required by licensing standards. Allowable costs shall include the reasonable cost of all items of expense, which providers incur in the provision of routine services.

04/98 B. Other items as indicated by the HFS may be identified as non-allowable, but shall not include any item specified in A. of this section.

11/06 C. All related organizations doing business with the facility, and the specific transactions, must be identified on the cost report. Allowable costs of purchases of any item or service from a related organization are restricted to the costs allowed by Medicare guidelines as specified in the *Provider Reimbursement Manual* (publication #15).

10/09 D. For county-owned or –operated nursing facilities, rates shall include allowable costs paid by the county in excess of the reimbursement received from HFS. The process for calculating and claiming the Allowable Unreimbursed Routine Nursing Facility costs is detailed in subsection III.J. of this Attachment.

Payment by HFS for long- term care services shall not exceed reimbursable costs less what is contributed by third party liability.

E. Costs not related to patient care, as well as costs in excess of those required for the efficient and economical delivery of care, will be disallowed. Examples of non-allowable costs are:

1. Any service not related to direct nursing care such as day care, other outpatient care, non-patient meals, and non-patient laundry.
2. Any revenue producing amenities such as the gift and coffee shop, barber and beauty shop, and television and radio in the resident's room.

04/98 3. Any services which HFS pays for separately such as laboratory, radiology, and dental services.

4. Costs of items sold to patients or non-patients and the cost of any non-group care restricted drugs.
5. Any expenses incurred by the owner or owning corporation, which are not nursing care related. Such expenses would include the following:
   a. Non-working officer's salary
   b. Compensation to non-working owners
   c. Non-care related interest

d. Non-care related owners' transactions

e. Personal expenses of owner

f. Non-care related fees

g. Training program for non-employees

h. Fines and penalties

i. Entertainment

j. Contributions

k. Owner of key-man life insurance

l. Special legal fees

m. Non-care related patient transportation

n. Malpractice insurance for individuals

o. Non-patient related transportation and travel

p. Bad debts

6. Owners compensation in excess of compensation in comparable situations.

7. Non-straight line depreciation or depreciation in excess of Medicare guidelines.

8. Unnecessary interest expense as determined by HLM-15 guidelines.

9. Expenses incurred in transactions with related organizations above the cost of the organization providing those services as specified in HLM-15.

10. In determining allowable costs, no interest cost shall be recognized to the extent that it exceeds payment based on 125% of the prevailing mortgage rate at the time of the loan.

~~04/98~~10/09 11. Assessment fees required by *Public Act 87-861* or *Public Act 88-0088* to be paid to DPA are not allowable costs for reimbursement purposes, with the exception of the reimbursement for county-owned or -operated nursing facilities calculated in accordance with subsection III. J. of this Attachment.

10/09 12. Intergovernmental transfers from a county government to the Department.

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. 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.

10/09

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.

10/09

Except as referenced in subsection III.C.4.a.iii.(D)., t~~T~~he nursing component will be calculated and ~~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

(C) For the purposes of calculating the rate in subsection iii.(A), the annual mount 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.

10/09

(D) The ratios referenced in subsections III.C.4.a.iii.(A) and (B) shall only change annually.

E. Exceptional Care and Ventilator Care Reimbursement for Nursing Facilities

~~01/07~~10/09 1. Exceptional Care

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.

10/09 2. Ventilator Care

a. Effective October 1, 2009, reimbursement to nursing facilities for ventilator dependent residents will be determined through a system separate from the Minimum Data Set (MDS) based reimbursement methodology. For purposes of this subsection, ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

b. Payment shall be made for each individual resident receiving ventilator services through the Medicaid Management Information System (MMIS). The rate shall include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and $150 supply cost.

c. For a nursing facility to be eligible to receive ventilator service payments, the following staffing requirements must be maintained:

i. A minimum of one RN on duty on the day shift, seven days per week. Additional RN staff may be determined necessary by the Department, based on the Department's review of the ventilator services.

ii. A minimum of the required number of LPN staff on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week.

iii. A certified respiratory therapy technician or registered respiratory therapist shall be available at the facility or on call 24 hours a day.

iv. A certified respiratory therapist shall evaluate and document the respiratory status of the ventilator resident on a weekly basis.

v. At least one of the full-time licensed 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 experience in the care of ventilator dependent persons.

~~01/07~~10/09 ~~[Reserved]~~

vi. All staff caring for ventilator dependent residents must have documented in-service training in ventilator care prior to providing that care. In-service training must be conducted at least annually by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent persons. In-service training documentation shall include name and qualification of the in-service director, duration of presentation, content of presentation and signature and position description of all participants.

d. For a nursing facility to be eligible to receive ventilator service payments, the provider shall have and maintain physical plant adaptations to accommodate the necessary equipment, such as, an emergency electrical backup system.

iv. The Administrator will send by mail written notification to the facility of the determination of the second level review within forty-five (45) calendar days of the receipt of the facility's request for second level review. No other administrative review will be available.

I. Appeals of Rate Determinations

04/98 1. Appeals of rate determinations shall be submitted in writing to HFS. All appeals submitted within 30 days of rate notification shall, if upheld, be made effective as of the beginning of the rate year. The effective date of all other upheld appeals shall be the first day of the month following the date the completed appeal was submitted.

04/98 2. HFS shall rule on all appeals within 120 days of the date of appeal, except that if HFS requires additional information from the facilities. The service shall be extended until such time as the information is provided. Appeals for any rate year must be filed before the close of the said year.

~~11/06~~10/09 J. Reimbursement for county-owned or -operated nursing facilities – Allowable Unreimbursed Routine Nursing Facility Costs.

~~11/06~~ ~~Except for nursing facility services for which Medicare is the primary payer, the reimbursement for nursing facilities owned or operated by an Illinois County shall be a per diem rate equal to 94 percent of the average rate that is determined by applying a modified Medicare reimbursement methodology to the facility's Medicaid residents. The modification to the Medicare methodology shall consist of the use of the 34-class RUG grouper, in lieu of the 44-class grouper used by Medicare. The difference between the 34-class RUG grouper and the 44-class RUG grouper is that the 34-class RUG grouper only recognizes four rehabilitation groupings (RAD, RAC, RAB, and RAA) instead of the 14 used by Medicare.~~

~~11/06~~ ~~For purposes of the calculation, the Medicare rate will be based upon the resident assessment instrument (MDS) data transmitted to the State for Medicaid residents, who were in the facility on the 15th day of February preceding the beginning of the State fiscal year during which the service was provided. The MDS data will be used to assign each resident a RUG. The rate will be based upon the latest Medicare PPS rate, using the latest wage indices for urban and rural areas published in the *Federal Register*. The four rehabilitation group rates will be calculated as follows. The RAD and RAC rates will be the average of the Medicare RMC and RLB rates. The RAB rate will be the average of the Medicare RMB and RLA rates. The RAA rate will be the average of the Medicare RMA and RLA rates. The resulting rates for all Medicaid clients, within a facility will be averaged at a facility level. Payment rates will be adjusted effective with any adjustments made to the Medicare PPS rates by CMS.~~

10/09 1. Federal Financial Participation (FFP) will be claimed based on public funds expended for routine nursing home care services for Medicaid fee-for-service residents under 42CFR433.51(b).

2. As described in section III.C. of this Attachment, Illinois reimburses county nursing facilities a daily rate for routine nursing home services provided to Medicaid recipients.

When the total allowable cost based per diem rate, as described below, exceeds the daily payment rate for the routine nursing services, the deficit is certified by the county nursing facilities and is eligible for Federal matching. A claim for Federal matching will be made on a per diem basis by the State using the certification from the County nursing facility which is based upon cost reports filed by the County nursing facility.

3. Data Sources Utilized for the Calculation of the Total Allowable Cost Based Per Diem Rate.

   a. Medicaid cost reports will be used as the basis for determining the total allowable cost based per diem rate. Not all facilities participate in the Medicare program, while others only submit low utilization cost reports that do not contain the detailed cost information necessary to determine allowable costs. Therefore, Medicaid cost reports will provide the most consistent format for cost finding, allocations and final settlement.

   b. An interim allowable cost based per diem rate will be calculated for each rate year using the most recent cost and utilization information available. A final settlement of the total allowable cost based per diem rate will be determined based upon the final audited cost report for each facility's cost report year.

   c. Allowable costs are defined in Section II. of this Attachment. Allowable routine costs are pulled from the following cost report schedules:

      i. Total Operating Expense – Schedule V., line 29, column 10
      ii. Total Ownership Expense – Schedule V., line 37, column 10
      iii. Provider Participation Fee – Schedule V., line 42, column 10

   d. The following non-allowable cost items are subtracted from the allowable cost total determined in subsection III.J.3.c. above:

      i. Nurse Aid Training – Schedule V., line 13, column 10
      ii. A portion of the following Administrative Costs allocated to non-reimbursable cost centers from Schedule V. (Non-reimbursable cost centers include the Ancillary Service Center line 39, Barber and Beauty Shops line 40, and Coffee and Gift Shops line 41).

         (A) Ownership will be allocated based upon the percentage of square feet associated with the non-reimbursable cost center lines. Ownership costs will include:

            (1) Depreciation – Schedule V., line 30, column 10
            (2) Amortization of Pre-Op. & Org. – Schedule V., line 31, column 10 (if applicable)
            (3) Interest – Schedule V., line 32, column 10

(4) Real Estate Taxes – Schedule V., line 33, column 10 (if applicable)

(5) Rent-Facility and Grounds – Schedule V., line 34, column 10 (if applicable)

(B) Employee Benefits – Schedule V., line 22, column 10 – will be allocated based upon the percentage of Salary Expense in the non-reimbursable cost center lines.

(C) Administration and General will be allocated based upon the percentage of accumulated costs in the non-reimbursable cost center lines. Administration and General costs will include:

(1) General Administration – Schedule V., line 28, column 10, less Employee Benefits allocated above.

(2) Provider Participation Fee – Schedule V., line 42, column 10

(3) Rent – Equipment and Vehicles – Schedule V., line 35, column 10

(D) Plant Operations will be allocated based upon the percentage of square feet associated with the non-reimbursable cost center lines. Plant Operations will include:

(1) Heat and Other Utilities – Schedule V., line 5, column 10.

(2) Maintenance – Schedule V., line 6, column 10

(E) Housekeeping – Schedule V., line 3, column 10 – will be allocated based upon the percentage of square feet associated with the non-reimbursable cost center lines.

4. Calculation of the Total Allowable Cost Based Per Diem Rate.

a. Total allowable costs will equal the sum of the allowable costs identified in subsection III.J.3.c. less the non-allowable costs identified in subsection III.J.3.d.

b. The total allowable cost based per diem rate will equal the total allowable costs calculated in subsection III.J.4.a. divided by the total patient days (Medicaid cost report page 2, line 14, column 5), and inflated to the midpoint of the rate year by the increase in the CMS Prospective Payment System Skilled Nursing Facility Input Price Index.

5. Calculation of the Allowable Unreimbursed Routine Nursing Facility Costs.

a. On a per diem basis, the allowable unreimbursed routine nursing facility costs will equal the total allowable cost based per diem rate, as calculated in subsection III.J.4., less the daily nursing rate, as described in Section III.C. of this Attachment, as well as any other Medicaid payments and any payments received from patients or third party payors for the routine nursing facility services.

b. The allowable unreimbursed routine nursing facility cost per diem, as calculated in subsection III.J.5.a., will be applied to each Medicaid patient day provided by the County nursing facility. On a quarterly basis, a claim for Federal financial participation will be submitted that is equal to the total Medicaid patient days provided in the quarter multiplied by the allowable unreimbursed routine nursing facility cost per diem for each County nursing facility.

6. Initial Cost Settlement

   a. If final audits are not completed within 180 days after the last County nursing facility cost report is required to be submitted to the State, an initial settlement of the allowable cost based per diem rate and the allowable unreimbursed routine nursing facility costs will be calculated.

   b. This settlement will be for services provided in the cost reporting period and will include initial audit adjustments and reclassifications posted to the system.

   c. The allowable cost based per diem rate and the allowable unreimbursed routine nursing facility costs be recalculated using the methodology described in subsections III.J.4. and III.J. 5 based upon the actual cost report and claims information, including actual Medicaid patient days and Medicaid payment data for the service period from MMIS.

   d. Adjustments will be computed for each Medicaid patient day in the cost reporting period, with the federal share of any overpayment credited back to the federal government.

7. Final Cost Settlement

   a. Upon completion of the final audit of the facility cost reports, a final settlement of the allowable cost based per diem rates and the allowable unreimbursed routine nursing facility costs will be calculated. This final settlement will be completed within two years after the last County nursing facility cost report is required to be submitted to the State.

   b. This settlement will be for services provided in the cost reporting period and will include final audit adjustments and reclassifications posted to the system.

   c. The allowable cost based per diem rate and the allowable unreimbursed routine nursing facility costs will be recalculated using the methodology described in subsections III.J.4. and III.J. 5 based upon the actual cost report and claims information, including actual Medicaid patient days and Medicaid payment data for the service period from MMIS.

   d. Adjustments will be computed for each Medicaid patient day in the cost reporting period, with the federal share of any overpayment credited back to the federal government.

OS Notification

State/Title/Plan Number: Illinois 09-008

Type of Action: SPA Approval

Required Date for State Notification: December 6, 2011

Fiscal Impact:

FY 2010	$7,200,000
FY 2011	$6,700,000

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail:

Effective for services on or after October 1, 2009, this amendment revises methods and standards for establishing payment rates for nursing facility services. Specifically, this amendment would allow the State to claim for allowable costs, paid by county-owned or operated NFs, in excess of reimbursement received by the NF; create a separate per diem reimbursement for ventilator dependent residents in all NFs. Funding the non-Federal share comes from CPE and state appropriations. The State met public process requirements. There are no issues with the UPL.

This SPA required a lengthy review time, because the State needed to demonstrate that the State-specific Medicaid cost report they intend to use to identify allowable unreimbursed routine NF costs is a reasonable proxy for the CMS 2540. Additionally, the State needed to provide a detailed protocol for identifying allowable unreimbursed routine NF costs. The State doesn't feel they'll have any problems with the 2 year timely filing requirements.

This amendment proposes to create a separate per diem reimbursement for ventilator dependent residents in all NFs. The rate will include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and $150 supply cost.

Additionally, this amendment provides that for county-owned or operated NFs, allowable costs paid by the County NF in excess of the regular NF reimbursement rate can be claimed by the State for FFP using a CPE methodology as provided for under 42 CFR 433.51(b). CMS has worked with the State on a detailed protocol for identifying the "allowable unreimbursed routine NF costs" and the calculation methodology for claiming FFP.

Also, the CPE from the Counties would be considered new contribution, from political subdivisions, toward the non-federal share of expenditures under the Medicaid State plan for purposes of Section 5001(g)(2) of ARRA. The State has provided assurance to CMS that they will provide a statement from each of the Counties that the new contribution is "voluntary" as is required

according to the SMD letter #10-010 dated June 21, 2010.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

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