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State/Territory Name: IL

State Plan Amendment (SPA) #: 22-0009

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

July 7, 2022

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

RE: State Plan Amendment (SPA) 22-0009

Dear Ms. Eagleson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 22-0009. This amendment proposes to adjust the reimbursement methodology for nursing facilities to align with the Medicare Patient Driven Payment Model (PDPM), incentivize quality care and staffing levels, and include a $70 million annual quality incentive payment tied to Long Stay STAR ratings.

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 have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July, 1, 2022. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0009

2. STATE: IL

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.40

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 105,000,000
b. FFY 2023 $ 420,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Pages 17-23, 73A - 73D, 120B

(73A-73D new pages)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Pages 17-23, 120B

9. SUBJECT OF AMENDMENT

Reimbursement to nursing facilities.

10. 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
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Theresa Eagleson

13. TITLE
Director of Healthcare and Family Services

14. DATE SUBMITTED
April 22, 2022

15. RETURN TO
Department of Healthcare and Family Services
Bureau of Program and Policy Coordination
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR CMS USE ONLY

16. DATE RECEIVED
4/22/2022

17. DATE APPROVED
July 7, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director

22. REMARKS

6/1/2022 - State submitted new language on 4.19-D page 73C which was not included in original submission and removed page 80, updated block 7 and block 8

7/6/2022 - New page 73D included in block 7

01/14 4. Nursing and Program Costs

a. Effective January 1, 2014, an evidence-based payment methodology will be used for the reimbursement of nursing services. The methodology takes into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Minimum Data Set (MDS), adopted and in use by the federal government.

i. This Section establishes the method and criteria used to determine the resident reimbursement classification based upon the assessments of residents in nursing facilities.

07/22 A) Effective January 1, 2014, resident reimbursement classification shall be established utilizing the 48-group, Resource Utilization Groups IV (RUG-IV) classification scheme and weights as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

07/22 B) Effective July 1, 2022, resident reimbursement classification shall be established utilizing the Patient Driven Payment Model (PDPM) nursing component classification methodology and associated weights, as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as of March 1, 2022, multiplied by 0.7858 and rounded to the nearest four decimal places.

C) An Illinois specific default group is established in subsection (iii)(E) of this Section and with an assigned weight equal to the weight assigned to group PA1.

ii. The statewide nursing base per diem rate effective on:

A) January 1, 2014, shall be $83.49.

B) July 1, 2014, shall be $85.25.

07/22 C) July 1, 2022, shall be $92.25.

iii. For services provided on or after January 1, 2014:

A) The Department shall compute and pay a facility-specific nursing component of the per diem rate as the arithmetic mean of the resident-specific nursing components assigned to Medicaid-enrolled residents on record, as of 30 days prior to the beginning of the rate period, in the Department's Medicaid Management Information System (MMIS), or any successor system, as present in the facility on the last day of the second quarter preceding the rate period.

07/22

1) The RUG-IV nursing component per diem for a nursing facility shall be the product of the statewide nursing base per diem rate, the facility average case mix index as identified in subsection 4.a.i.A., to be calculated quarterly, and the regional wage adjustor, and then to this product add the Medicaid access adjustment as defined in 4.a.iii.D.

07/22

2) Effective July 1, 2022, the PDPM nursing component per diem for a nursing facility shall be the product of the statewide nursing base per diem rate, the facility average PDPM nursing component case mix index multiplied by .7858, as identified in subsection 4.a.i.B., to be calculated quarterly, and the regional wage adjustor, and then to this product add the Medicaid access adjustment as defined in 4.a.iii.D.

07/22

3) Transition rates for services provided between July 1, 2022, and October 1, 2023, shall be the greater of the PDPM nursing component per diem, defined in subparagraph 4.a.iii.A,2, or:

   a) for the quarter beginning July 1, 2022, the RUG IV nursing component per diem, defined in subparagraph 4.a.iii.A.1.

   b) for the quarter beginning October 1, 2022, the sum of the RUG-IV nursing component per diem multiplied by 0.80 and the PDPM nursing component per diem multiplied by 0.20.

   c) for the quarter beginning on January 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.60 and the PDPM nursing component per diem multiplied by 0.40.

   d) for the quarter beginning on April 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.40 and the PDPM nursing component per diem multiplied by 0.60.

   e) for the quarter beginning on July 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.20 and the PDPM nursing component per diem multiplied by 0.80.

4) For the quarter beginning on October 1, 2023 and each subsequent quarter, nursing facilities shall be paid 100% of the PDPM nursing component per diem.

B) Effective for dates of service on or after July 1, 2014, a per diem add-on to the RUGS methodology will be included as follows:

1) $0.63 for each resident that scores I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

2) $2.67 for each resident that scores "1" or "2" in any items S1200A through S1200I and also scores in the RUG groups PA1, PA2, BA1, and BA2.

C) Effective July 1, 2022, a variable per diem staffing add-on shall be paid to facilities with at least 70% of the staffing indicated by the STRIVE study. The add-on will be based on information from the most recent available federal staffing report, currently the Payroll Based Journal, adjusted for acuity using the same quarter's MDS. Specifically, that percentage will reflect column headings utilized on April 1, 2022 titled "Reported total nurse staffing hours per resident per day" divided by "Case-mix total nurse staffing hours per resident per day" from the Provider Information tables available through the Federal COMPARE website..

1) Facilities at 70% of the staffing indicated by the STRIVE study shall be paid a per diem of $9, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem of $14.88.

2) Facilities at 80% of the staffing indicated by the STRIVE study shall be paid a per diem of $14.88, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem of $23.80.

3) Facilities at 92% of the staffing indicated by the STRIVE study shall be paid a per diem of $23.80, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem of $29.75.

4) Facilities at 100% of the staffing indicated by the STRIVE study shall be paid a per diem of $29.75, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem of $35.70.

5) Facilities at 110% of the staffing indicated by the STRIVE study shall be paid a per diem of $35.70, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem of $38.68.

6) Facilities at or above 125% of the staffing indicated by the STRIVE study shall be paid a per diem of $38.68.

7) For the transition period quarters beginning July 1, 2022, and October 1, 2022, no facility's variable per diem staffing add-on shall be calculated at a rate lower than 85% for the staffing indicated by the STRIVE study. For the quarter beginning January 1, 2023, all facilities shall begin at their actual staffing indicated for that period.

8) No facility below 70% of the staffing indicated by the STRIVE study shall receive a variable per diem staffing add-on after December 31, 2022.

9) Beginning April 1, 2023, no nursing facility's variable per diem staffing add-on shall be reduced by more than 5% in 2 consecutive quarters.

D) Effective July 1, 2022 and until December 31, 2027, a Medicaid Access Adjustment shall be paid to all facilities with annual Medicaid bed days of at least 70% of all occupied bed days.

1) The adjustment shall be $4 per day and adjusted for the facility average PDPM case mix index for Medicaid, as identified in subsection 4.a.i.A., calculated on a quarterly basis.

2) The qualifying Medicaid percentage shall be calculated quarterly based upon a rolling 12 month period of historical data ending 9 months prior.

3) If a facility's Medicaid percentage increases by 15 percentage points or more in comparison to the qualifying Medicaid percentage defined in 4.a.iii.D.2 and the facility's most recent Medicaid percentage for a single quarter is at least 70%, that facility may be eligible to receive the Medicaid Access Adjustment. If a facility's Medicaid percentage decreases by 15 percentage points or more in comparison to the qualifying Medicaid percentage defined in 4.a.iii.D.2 and the facility's most recent Medicaid percentage for a single quarter is no longer at least 70%, that facility may no longer be eligible to receive the Medicaid Access Adjustment.

07/22 E~~)~~ A resident for whom resident identification information is missing, or inaccurate, or for whom there is no current MDS record for that quarter, shall be assigned to default group AA1. A resident for whom a MDS assessment does not meet the CMS edit requirements as described in the Long Term Care Resident Assessment Instrument (RAI) Users Manual or for whom a MDS assessment has not been submitted timely shall be assigned to default group AA1.

F) The assessment used for the purpose of rate calculation shall be identified as an Omnibus Budget Reconciliation Act (OBRA) assessment on the MDS following the guidance in the RAI Manual.

G)The MDS used for the purpose of rate calculation shall be determined by the Assessment Reference Date (ARD) identified on the MDS assessment.

01/20 H) Effective January 1, 2020, the regional wage adjustor referenced in paragraph (A) cannot be lower than 0.95.

07/20 I) Effective July 1, 2020, the regional wage adjustor referenced in paragraph (A) cannot be lower than 1.0.

07/22 J) Effective July 1, 2022, the regional wage adjustor applied to the PDPM nursing component per diem cannot be lower than 1.06.

vi. The Department shall provide each nursing facility with information that identifies the group to which each resident has been assigned.

10/15

v. Minimum Data Set On-Site Reviews

A) The Department shall conduct reviews to determine the accuracy of the resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. The MDS data used by the Department to set the reimbursement rate will be used to conduct the validation reviews. Such reviews may, at the discretion of the Department, be conducted electronically or onsite in the facility.

07/22

B) Recalculation of Reimbursement Rate. The Department shall determine if the reported MDS data that was subsequently determined to be unverifiable would cause the direct care component of the facility's rate to be calculated differently when using the accurate data. If reviews establish a pattern of inaccuracy, those results may be extrapolated and applied to all applicable rates in the facility.

07/22

C) A facility's rate shall be subject to change for a period of at least two quarters if the recalculation of the direct care component rate, as a result of using MDS data that is verifiable:

1) Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

2) Decreases the rate by more than 10 percent in addition to the rate change specified in this section. The direct care component of the rate may be reduced, retroactive to the beginning of the rate period, by $1.00 for each whole percentage decrease in excess of 2 percent.

D) Based on the areas identified as reclassified, the nursing facility may request that the Department reconsider the assigned classification. The request for reconsideration shall be submitted in writing to the Department within 30 days after the date of the Department's notice to the facility. The request for reconsideration shall include the name and address of the facility, the name of each resident in which reconsideration is requested, the reasons for the reconsideration for each resident, and the requested classification changes for each resident based on the MDS items coded. In addition, a facility may offer explanations as to how they feel the documentation presented during the review supports their request for reconsideration. However, all documentation used to validate an area shall be submitted to the Department prior to exit. Documentation presented after exit will not be considered when determining a recalculation request. If the facility fails to provide the required information with the reconsideration request, or the request is not timely, the request shall be denied.

E) The Department shall have 120 days after the date of the request for reconsideration to make a determination and notify the facility in writing of the final decision.

9. Optional Nursing Facility Quality Component Payments

   a. Certified Nursing Assistant (CNA) Tenure and Promotion Payments.

      i. CNA Tenure Payments will be based on each CNA's years of experience. These payments will be paid to nursing facilities equal to Medicaid's share of the following tenure wage increments:

         A) An additional $1.50 per hour for CNAs with at least one and less than two years of experience as a practicing CNA, plus

         B) An additional $1 per hour for each additional year of experience, up to a maximum of $6.50 per hour for CNAs with at least 6 years of experience.

         C) Payments will be calculated based on all reported CNA employee hours compensated in accordance with an operative pay scale consisting of tenured increments at least as large as those specified in subparagraphs A and B above and posted in a manner consistent with Federal workplace posters. The pay scale should result in increased compensation, not reductions in compensation, for CNAs. Postings should convey the pay scale so that employees are reasonably able to apply it to their own circumstances and wage rate.

         D) Medicaid's share for each nursing facility shall be the ratio of paid Medicaid days divided by total bed days for the same period.

         E) Monthly payments will be made to facilities on a ~~per diem~~ prospective basis equal to the number of qualifying CNA hours published on the Federal COMPARE website, as matched to CNA experience levels determined using information submitted by nursing facilities to the Department and through quarterly PBJs where consistent with employment histories reflected in the Department of Public Health's workforce certification registry, and multiplied by the ratio of paid Medicaid days to total bed days for the year ending 9 months prior.

ii. Optional CNA Promotion Payments will be paid to nursing facilities equal to Medicaid's share of $1.50 per hour for each qualifying promotion-based wage increment, as follows:

A) To qualify for this payment, the promotion-based wage increment must be at least $1.50 per hour to qualify for this payment.

B) Qualifying promotions are for CNAs that are assigned intermediate, specialized or added roles, such as trainers, schedulers or specialists for specific resident conditions, and will be limited to 15% of employed CNAs as measured on a full time equivalent basis.

C) Payments will be calculated based on all reported CNA employee hours compensated in accordance with the promotional wage increase specified in subparagraph A.

D) Medicaid's share for each nursing facility shall be the ratio of paid Medicaid days divided by total bed days for the same period.

E) Monthly payments will be made to facilities on a prospective basis equal to the number of qualifying CNA hours published on the Federal COMPARE website, as matched to professional roles for each CNA reported by each facility, multiplied by the ratio of paid Medicaid ~~base~~ days to total bed days for the year ending 9 months prior.

b. Incentive Payments will be paid to nursing facilities determined by facility performance on specified quality measures. The quality payment methodology described in this Section will be used for July 1, 2022 through June 30, 2023. Facilities designated by the Centers for Medicare and Medicaid Services as a special focus facility, or a hospital-based nursing home do not qualify for quality payments.

i. The Quality Incentive Pool will initially be $70,000,000 annually or $17,500,000 per quarter.

ii. Distribution of the Quality Incentive Pool will be based on a quality weight score for each nursing facility, which is calculated quarterly by multiplying the nursing facility's paid Medicaid days by the nursing facility's star rating weight for the most recent available quarter. Paid Medicaid days will be calculated quarterly based upon a rolling 12 month period of historical data ending 9 months prior to the payment effective date, inclusive of hospice and provisional days, if applicable, and annualized where necessary and appropriate.

iii. Star rating weights are assigned based on the nursing facility's star rating for the long stay quality rating as assigned by the Centers for Medicare and Medicaid Services under the Five-Star Quality Rating System for the most recent available quarter. Weights will be assigned as follows:

A) Zero or one star rating has a weight of 0.

B) Two star rating has a weight of 0.75.

C) Three star rating has a weight of 1.5.

D) Four star rating has a weight of 2.5.

E) Five star rating has a weight of 3.5.

iv. Each nursing facility's quality weight score is divided by the sum of all quality weight scores to determine the proportion of the Quality Incentive Pool to be paid to each nursing facility. Until additional quality measures are adopted by the Department as part of the quality incentive payments, the dollar value calculated for each star rating for the implementing quarter shall serve as the floor for each star's dollar value for each quarter thereafter. However, the dollar value per Medicaid day may still fluctuate to offset the impact on total payments of increases or decreases in the statewide number of Medicaid days.

v. Final payment amounts will be calculated based on the proportion of paid Medicaid days for individuals not enrolled in a Medicaid managed care plan. Payments will be distributed on a quarterly basis.

vi. When necessary, the absence of available data or data limitations will be addressed through Department policy.

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

07/18 Notwithstanding the provisions set forth in this Section, effective for services beginning July 1, 2018, facilities with more than 16 licensed beds licensed by the Department of Public Health under the ID/DD Community Care Act [305 ILCS 5] located in the Department of Public Health's Planning Area 7-B, will receive a $21.15 increase to their per diem rate in effect on June 30, 2018.

07/22– Notwithstanding the provisions set forth for maintaining rates at the levels in effect on January 18, 1994, a nursing facility's rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities (SNF/ICF) effective on July 1, 2019, shall be computed by adding a 3.45% increase to the greater of 90.8% of the rate calculated from the latest cost report on file March 31, 2015 or the support rate in effect on June 30, 2019. From July 1, 2019 through June 30, 2022, the nursing facility's direct care component will receive a $4.55 per diem add-on. A facility that fails to meet the benchmarks and dates contained in the annually approved staffing plan will have the add-on reduced to $0 in the quarter following the quarterly review.