



HEALTHCARE AND FAMILY SERVICES

NURSING HOME RATE CALCULATION

HANDBOOK

FY 2023

Effective July 1, 2022

INTRODUCTION

This packet is designed to assist facilities in calculating July 1, 2022 nursing reimbursement rates, as well as associated lump sum quality incentive payments and certified nursing assistant (CNA) experience and promotion incentive payments. It contains step-by-step instructions for calculating these components of the reimbursement rates. The methodology for the calculation of the support services and capital components of the reimbursement rates remains unchanged from prior reimbursement periods.

REIMBURSEMENT SYSTEM FOR NURSING FACILITIES GENERAL DESCRIPTION

Key Features

The Illinois reimbursement system for nursing facilities is a prospective system; that is, the rates are set for each facility for a subsequent rate period. The rates remain in effect for the rate period and there is no retroactive reconciliation of rates to actual expenditures during the rate period.

The reimbursement rates are facility specific. Individual rates are set for each nursing facility, taking into account such factors as, individual facility costs, variations in resident case mix, geographical location, and other facility characteristics such as occupancy level.

Illinois uses a case mix or resident needs based system to establish the direct care payment rate. The direct care rate is based on a measure of a nursing facility's resident case mix, which reflects the individual needs of residents within the facility and the actual services being provided to the residents. A quarterly Minimum Data Set (MDS) assessment for each Medicaid-eligible resident is used to determine the average resident need and service levels within each nursing facility. This provides the basis for determining the direct care reimbursement rate.

Components of the Reimbursement Rate

The reimbursement rate has three components:

1. Nursing and Direct Care Component
 - a. CNA Experience and Promotion Incentive Payment (Lump Sum)
 - b. Quality Incentive Payment (Lump Sum)
2. Support Service Component
3. Capital Component

1. Nursing and Direct Care Component

The nursing and direct care component covers costs associated with direct care, nursing, and other group care related health and treatment services. The rate includes payment for assisting residents in meeting basic functional and special health needs and for rehabilitative and restorative nursing care, as well as an incentive payments for staffing.

The facility rate is based on an OBRA MDS assessment for each Medicaid-eligible resident, which is completed initially upon admission and then quarterly for the duration of the resident's stay in the LTC facility. Medicare Patient Driven Payment Model (PDPM) nursing component case mix group designations are determined for each resident and the Centers for Medicare and Medicaid Services (CMS) published Case Mix weights as of April 1, 2022 (modified for Illinois budget neutrality) are compiled to determine the case mix for each facility. The facility average case mix is multiplied by the regional wage factor for the facility and by the statewide base rate. This is the facility's MDS base rate. During the initial PDPM case mix implementation period (July 1, 2022 – September 30, 2023) a comparison of the facility average PDPM case mix to the Resource Utilization Group (RUG-IV) 48 group facility average case mix will be performed and individual rates may be adjusted as a result. The calculation is described in more detail in PART I of the handbook.

The statewide nursing base per diem rate effective on July 1, 2022 is \$92.25.

The add-on for each Alzheimer/Dementia resident as determined by I4200 and I4800 is \$0.63.

The add-on for each serious mental illness (SMI) resident in the lower 4 RUG groups as determined by S1200 A- I is \$2.67.

The add-on for each Traumatic Brain Injury (TBI) resident is \$5.00. Rule 147.335 may be found at <http://www.ilga.gov/commission/jcar/admincode/089/089001470003350R.html>.

Effective July 1, 2022, the previously legislated per diem add-on of \$4.55 has been replaced in the direct care per diem by a staffing incentive add-on which ranges on a sliding scale from \$0.00 to \$38.68 depending on each facility's percentage of actual reported total nurse staff hours from Payroll-Based Journal (PBJ) submissions as compared to the total case mix Staff Time Resource Intensity Verification (STRIVE) nurse staff hours as published by CMS on <https://data.cms.gov/>. Case mix nurse staff hours represent the STRIVE target level of staffing for each facility for the quarter.

Effective July 1, 2022 and until December 31, 2027, a Medicaid Access Adjustment shall be included in the nursing and direct care component and paid to all facilities with annual Medicaid bed days of at least 70% of all occupied bed days (Medicaid percentage). The Medicaid Access Payment is determined as follows:

- 1) The adjustment shall be \$4.00 per day and adjusted for the facility average PDPM case mix index for Medicaid.

- 2) The qualifying Medicaid percentage shall be calculated quarterly based upon paid days from the State's Medicaid Management Information System (MMIS) for a rolling 12-month period of historical data ending 9 months prior. For each new quarter beginning July 1, 2022, a facility's percentage of Medicaid bed days shall be paid Medicaid resident days per annum as determined by adding the number of Medicaid, Medicaid Managed Long Term Services & Supports (MLTSS) and Medicare-Medicaid Alignment Initiative (MMAI) days (inclusive of hospice and provisional days, if applicable) divided by the number of total occupied days found in the corresponding months of Long Term Care Provider Assessment Reports for the facility that are available to the Department.

A facility's rate depends on the resident need and service levels and the geographic location of the facility. Nurse aide training expenditures are reimbursed through separate systems.

The MDS data used by the Department to set the reimbursement rate may be subject to validation reviews performed by the Department or their designee. Such reviews may be conducted electronically or onsite in the facility. Nursing component rates may be adjusted based on the findings. Rules concerning MDS On-Site Reviews may be found at: <http://www.ilga.gov/commission/jcar/admincode/089/089001470003400R.html>

1A. CNA Experience and Promotion Incentive Payment

This optional program provides facilities with a subsidy payment to qualifying facilities for the Medicaid share of a statutory minimum pay scale for CNA experience and/or promotional wage enhancements. CNA experience wage subsidies range from \$0.00 to \$6.50 for each CNA hour that is (proportionally) attributable to a Medicaid resident, depending on years of experience. The CNA promotion wage subsidy is equal to \$1.50 per qualifying Medicaid CNA hour.

The Medicaid share (i.e., percentage, or proportion) of a qualifying pay scale shall be calculated quarterly based upon a rolling 12-month period of historical data ending 9 months prior. For each new quarter beginning July 1, 2022, a facility's percentage of Medicaid bed days shall be equal to paid Medicaid resident days per annum as determined by adding the number of Medicaid, Medicaid MLTSS and MMAI days (inclusive of hospice and provisional days, if applicable) divided by the number of total occupied days found in the corresponding months of Long Term Care Provider Assessment Reports for the facility that are available to the Department. Qualifying CNA hours by CNA experience level and promotion are multiplied by applicable per hour wage subsidy values, and this product is then multiplied by the calculated Medicaid percentage to determine the total quarterly incentive payment.

The payment will be made as a monthly lump sum payment paid through the Medicaid fee-for-service system and by each managed care and MMAI plan through a directed payment based on their proportion of facility specific Medicaid days. The monthly lump sum payment is calculated as the total quarterly incentive payment value divided by three.

1B. Quality Incentive Payment

This payment provides for reimbursement to facilities for their demonstrated performance on measures of specific resident outcomes. The quality incentive payment is based on each facility's Long Stay Quality Measures star published by CMS on <https://data.cms.gov/>. The statewide quality incentive payment pool will be no less than \$70 million dollars annually, or \$17.5 million dollars quarterly. The quarterly pool of \$17.5 million dollars will be distributed based on the percentage of each provider's quality adjusted Medicaid days divided by total statewide quality adjusted Medicaid days. Quality adjusted Medicaid days are determined by multiplying each facility's Medicaid days by the quality weighting factor based on each facility's achieved star value for the selected quality measure. Higher star values equate to higher weighting values ranging from 0 to 3.5.

Facility Medicaid days shall be calculated quarterly based upon paid days from the State's MMIS system for a rolling 12-month period of historical data ending 9 months prior. For each new quarter beginning July 1, 2022, a facility's Medicaid bed days shall be paid Medicaid resident days per annum as determined by adding the number of Medicaid, Medicaid MLTSS and MMAI days (inclusive of hospice and provisional days, if applicable) divided by four.

The payment will be made as a quarterly lump sum payment paid through the Medicaid fee-for-service (FFS) system and by each managed care and MMAI plan through a directed payment based on their proportion of facility specific Medicaid days.

2. Support Services Component

The support service rate covers the general service and administration costs associated with residential care. It includes costs of food, laundry, housekeeping, utilities, maintenance, administration, insurance, dietary, and general office services. These are costs that do not vary significantly with varying resident need levels.

Allowable costs for each facility are compiled from the facility cost report and updated to the rate year using various updating factors. The per diem per capita cost for each facility is derived and these costs for all facilities within designated geographic regions of the State are ranked from highest to lowest. The cost value at the 75th percentile is set as the ceiling for payment.

Facilities with per diem costs at or above the 75th percentile ceiling are reimbursed at a level equal to the 75th percentile value. Facilities having per diem per capita costs below the 75th percentile receive their full per diem per capita cost, plus a profit payment. The profit payment serves as an incentive for efficient and economic operation of the facility.

3. Capital Component

The capital rate provides reimbursement for the capital costs that include mortgage interest and asset depreciation but does not use these “costs” in the rate calculation. The rate is calculated based upon a blending of

- 1) The inflated historical cost per bed of the building
- 2) The uniform cost per bed for all facilities in the same age and region.

This blended value per bed is multiplied by a rate of return on investment and converted to a per diem value. A standard amount is added for equipment, vehicle and working capital interest costs. Additionally, an inflated real estate tax cost per diem is added to arrive at the total capital rate.

The capital component methodology and rate are not being changed at this time. They will remain at the amount as reported on your last rate notification.

PART I

NURSING
COMPONENT
PER DIEM
CALCULATION

July 1, 2022

July 1, 2022
CALCULATION OF THE NURSING RATE

This part of the packet is for calculating the nursing rate effective July 1, 2022. The Minimum Data Set (MDS) nursing rate is based upon the Medicaid eligible residents in the facility on March 31, 2022 as determined by the Medicaid Management Information System (MMIS) on May 31, 2022, using the most recent OBRA MDS (A0310A=01, 02, 03, 04, 05, 06) assessment in the quarter ending March 31, 2022. Residents for whom MDS resident identification information is missing or inaccurate, or for whom there is not a current MDS assessment for the quarter shall be placed in the lowest acuity category for calculation purposes. The nursing component per diem rate will also include a variable staffing per diem add-on and Medicaid access payment as detailed below

To calculate your nursing rate, you will need to:

- Step 1: The statewide base rate in effect for July 1, 2022 will be \$92.25.
- Step 2: Apply a uniform regional wage factor (multiplier) of 1.06.
- Step 3: Determine the case mix weights for all Medicaid eligible residents based on the Patient Driven Payment Model (PDPM) Nursing Component case mix groups and the Resource Utilization Group (RUG-IV) 48 group status of each resident. Calculate the sum of the case mix weights for all Medicaid eligible residents under both methodologies. See Tables 2a and 2b for the published Case Mix weights.
- Step 4: Determine the total number of Medicaid eligible residents.
- Step 5: Calculate the facility average case mix for both PDPM and RUG-IV by dividing the totals in Step 3 by the total in Step 4. If the PDPM facility average case mix exceeds the RUG-IV facility average case mix, utilize the PDPM facility average case mix. If the RUG-IV facility average case mix index exceeds the PDPM facility average case mix, utilize the blending factors noted in table 3 to determine the blended facility average case mix for use in rate setting. Beginning October 1, 2023 only the PDPM facility average case mix will be utilized.
- Step 6: Calculate the facility MDS based nursing rates by multiplying \$92.25 in Step 1 by 1.06 (the uniform regional wage factor in Step 2), and then multiply this product by the blended facility average case mix calculated in Step 5.
- Step 7: Calculate the Alzheimer/Dementia add-on by taking the sum of the number of Alzheimer/Dementia residents from the MDS verification list and

dividing it by the total number of Medicaid Eligible residents in Step 4 and then multiplying the product by \$0.63.

Step 8: Calculate the SMI add-on for residents in the low 4 RUG groups by taking the sum of the number of serious mental illness (SMI) residents in the low 4 RUG groups from the MDS verification list and dividing it by the total number of Medicaid Eligible residents in Step 4 and then multiplying the product by \$2.67.

Step 9: Calculate the traumatic brain injury (TBI) add-on by taking the sum of the number of TBI residents from the MDS verification list and dividing it by the total number of Medicaid Eligible residents in Step 4 and then multiplying the product by \$5.00.

Step 10: Calculate the facility “% of STRIVE Target”. Divide the “Reported Total Nurse Staffing Hours Per Resident Day” by “Case-Mix Total Nurse Staffing Hours Per Resident Day” from the most recent Provider Information file published on <https://data.cms.gov/provider-data> to determine the facility’s “Percentage of STRIVE Target”.

For the July 1, 2022 and October 1, 2022 rate periods, the facility’s variable per diem staffing add-on will be reimbursed utilizing the GREATER OF the calculated facility “Percentage of STRIVE Target” OR 85%.

Step 11: Calculate the facility variable staffing per diem add-on. The determined “Percentage of STRIVE Target” from Step 10 is compared to the values in table 4 to determine the applicable variable staffing per diem.

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

Step 12: Determine the Medicaid Percentage for the Facility. Medicaid percentage is calculated as Medicaid days divided by total occupied bed days.

Medicaid days shall be calculated quarterly based upon paid claims from the State’s MMIS for a rolling 12-month period of historical data ending 9 months prior. For each new quarter beginning July 1, 2022, a facility’s percentage of Medicaid bed days shall be paid Medicaid resident days per annum as determined by adding the number of Medicaid, Medicaid Managed Long Term Services & Supports (MLTSS) and Medicare-Medicaid Alignment Initiative (MMAI) days (inclusive of hospice and provisional days, if applicable) divided by the number of total occupied days found in the corresponding months of Long Term Care Provider Assessment Reports for the facility that are available to the Department.

For example, the July 1, 2022, rate period would utilize MMIS paid claims

and Long Term Care Provider Assessment Report total occupied bed days from the period of October 1, 2020 – September 30, 2021 to determine Medicaid days and total occupied bed days respectively.

Step 13: Determine any adjustment to the Medicaid Percentage for recent material changes in Medicaid payer mix. Beginning with the October 1, 2022 rate period, the most recent 3 months of Medicaid and total occupied bed days from the Long Term Care Provider Assessment Reports will be compared to the Medicaid percentage calculated in Step 12 above to determine if providers have had a material change in Medicaid utilization percentage from the historical calculation period if certain conditions are met. The conditions are as follows:

- 1) If a facility's Medicaid percentage using the more current census information is at least 15% points higher than the percentage calculated in Step 12 above and the facility's most recent Medicaid percentage for a quarter is at least 70%, that facility may be eligible to receive the payments described in this section.
- 2) If a facility's Medicaid percentage is at least 15% points lower than the percentage calculated in Step 12 above and that facility's most recent Medicaid percentage for a quarter is no longer at least 70%, that facility may no longer be eligible to receive the payments described in this section.

Step 14: Calculate the Medicaid Access Payment. Effective July 1, 2022 and until December 31, 2027, a Medicaid Access Payment shall be paid to all facilities with annual Medicaid bed days of at least 70% of all occupied bed days (Medicaid percentage). For qualifying facilities, \$4.00 per day is multiplied by the facility average PDPM case mix index for Medicaid to determine the Medicaid Access Payment.

Step 15: The Facility calculated MDS per diem nursing rate is the sum of Step 6, Step 7, Step 8, Step 9, Step 11, and Step 14.

Table 1 -- Regional Wage Factors

HSA	Regional Wage Factor	HSA	Regional Wage Factor
1	1.0600	7	1.0600
2	1.0600	8	1.0600
3	1.0600	9	1.0600
4	1.0600	10	1.0600
5	1.0600	11	1.0600
6	1.0600		

Table 2a -- PDPM Nursing Component Case Mix Weights

PDPM Case Mix Group	PDPM HIPPS Code Character	National PDPM Weight As of April 1, 2022	PDPM Weights for Rate Setting (w/ Budget Neutral Factor of .7858)
ES3	A	4.06	3.1903
ES2	B	3.07	2.4124
ES1	C	2.93	2.3024
HDE2	D	2.40	1.8859
HDE1	E	1.99	1.5637
HBC2	F	2.24	1.7602
HBC1	G	1.86	1.4616
LDE2	H	2.08	1.6345
LDE1	I	1.73	1.3594
LBC2	J	1.72	1.3516
LBC1	K	1.43	1.1237
CDE2	L	1.87	1.4694
CDE1	M	1.62	1.2730
CBC2	N	1.55	1.2180
CA2	O	1.09	0.8565
CBC1	P	1.34	1.0530
CA1	Q	0.94	0.7387
BAB2	R	1.04	0.8172
BAB1	S	0.99	0.7779
PDE2	T	1.57	1.2337
PDE1	U	1.47	1.1551
PBC2	V	1.22	0.9587
PA2	W	0.71	0.5579
PBC1	X	1.13	0.8880
PA1	Y	0.66	0.5186
AA1	-	0.66	0.5186

Table 2b -- RUG Nursing Case Mix Weights (utilized until October 1, 2023 rate period)

RUG Group	National Nursing Case Mix Weights	RUG Group	National Nursing Case Mix Weights
ES3	3.00	PD2	1.15
ES2	2.23	CD1	1.15
ES1	2.22	RAB	1.10
HE2	1.88	CC2	1.08
HD2	1.69	PD1	1.06
RAE	1.65	LC1	1.02
LE2	1.61	CC1	0.96
RAD	1.58	LB1	0.95
HC2	1.57	CB2	0.95
HB2	1.55	PC2	0.91
LD2	1.54	PC1	0.85
HE1	1.47	CB1	0.85
CE2	1.39	RAA	0.82
RAC	1.36	BB2	0.81
HD1	1.33	BB1	0.75
LC2	1.30	CA2	0.73
CD2	1.29	PB2	0.70
LE1	1.26	PB1	0.65
PE2	1.25	CA1	0.65
CE1	1.25	BA2	0.58
HC1	1.23	BA1	0.53
HB1	1.22	PA2	0.49
LD1	1.21	PA1	0.45
LB2	1.21	AA1	0.45
PE1	1.17		

Table 3 -- PDPM and RUG Case Mix Percentage Blend

Rate Quarter Begin	RUG-IV Case Mix Percentage	PDPM Case Mix Percentage
7/1/2022	100.00%	0.00%
10/1/2022	80.00%	20.00%
1/1/2022	60.00%	40.00%
4/1/2023	40.00%	60.00%
7/1/2023	20.00%	80.00%
10/1/2023 and Beyond	0.00%	100.00%

Table 4 -- Staffing Per Diem Payment Table

Reported Total Nursing Hours as a Percentage of Case Mix (STRIVE) Total Nursing Hours	Per Diem Payment	Reported Total Nursing Hours as a Percentage of Case Mix (STRIVE) Total Nursing Hours	Per Diem Payment
125% and Above	\$38.68	96%	\$26.78
124%	\$38.48	95%	\$26.03
123%	\$38.28	94%	\$25.29
122%	\$38.08	93%	\$24.54
121%	\$37.89	92%	\$23.80
120%	\$37.69	91%	\$23.06
119%	\$37.49	90%	\$22.31
118%	\$37.29	89%	\$21.57
117%	\$37.09	88%	\$20.83
116%	\$36.89	87%	\$20.08
115%	\$36.69	86%	\$19.34
114%	\$36.49	85%	\$18.60
113%	\$36.30	84%	\$17.85
112%	\$36.10	83%	\$17.11
111%	\$35.90	82%	\$16.37
110%	\$35.70	81%	\$15.62
109%	\$35.11	80%	\$14.88
108%	\$34.51	79%	\$14.29
107%	\$33.92	78%	\$13.70
106%	\$33.32	77%	\$13.12
105%	\$32.73	76%	\$12.53
104%	\$32.13	75%	\$11.94
103%	\$31.54	74%	\$11.35
102%	\$30.94	73%	\$10.76
101%	\$30.35	72%	\$10.18
100%	\$29.75	71%	\$9.59
99%	\$29.01	70%	\$9.00
98%	\$28.26	Below 70%	\$0.00
97%	\$27.52		

PART IA

NURSING
COMPONENT LUMP
SUM PAYMENT
CALCUATION

CNA EXPERIENCE
AND PROMOTION
INCENTIVE PAYMENT

July 1, 2022

July 1, 2022
NURSING COMPONENT LUMP SUM PAYMENT
CALCULATION OF THE CNA EXPERIENCE AND PROMOTION INCENTIVE

This part of the packet is for calculating the monthly lump sum incentive payment for the certified nursing assistant (CNA) experience and promotion incentive payments effective for rate periods on or after July 1, 2022. This optional program provides facilities with a subsidy payment to qualifying facilities for the Medicaid share of employee CNA experience and promotion wage enhancements.

To be eligible for the CNA incentive program a facility must:

1. Must publish and display the CNA Experience and Promotion pay scales at the site of work, in a prominent and accessible place where it can easily be seen by workers and in a manner and location similar to that of Federal workplace posters. Postings should convey the pay scale so that employees are reasonably able to apply it to their own circumstances and wage rate.
2. Provider CNA Experience and Promotion pay scales must meet or exceed those specified by the Department for the CNA Incentive Payment period.
3. For each CNA Incentive Payment period, directly employed CNAs must be reimbursed additional hourly wage rates in accordance with posted CNA Experience and Promotion pay scales.
4. Complete the Department provided CNA Experience and Promotion templates and provide a signed certification prior to any specified deadlines

The payment will be made as a monthly lump sum payment paid through the Medicaid fee-for-service (FFS) system and by each managed care and Medicare-Medicaid Alignment Initiative (MMAI) plan through a directed payment based on their proportion of facility specific Medicaid days. The monthly lump sum payment is calculated as the total quarterly incentive payment value divided by three.

Facilities may opt into this program prior to beginning of each rate period by completing the templates and certification statements required by the Department.

To calculate your CNA experience and promotional incentive payment, you will need to:

- Step 1: Determine if your facility has met the eligibility requirements for the CNA experience and promotional incentive payment. The program is optional. To ensure eligibility, facilities must conform to the requirements in the Illinois Administrative Code, as well as the instructions within the Department provided CNA incentive payment template.
- Step 2: Complete the CNA experience and promotional template provided by Department. Facility must update CNA experience, promotional fields, and other fields as identified by template instructions.

- Step 3: Calculate the CNA experience hours available for the subsidy payment. From the CNA incentive template hours will be aggregated by years of experience in accordance with Table 1.
- Step 4: Calculate the total potential CNA experience subsidy amount. Aggregated CNA hours by years of experience will be multiplied by the applicable per hour subsidized wage amount as denoted in Table 1.
- Step 5: Calculate the CNA promotional hours available for the subsidy payment. From the CNA incentive template hours will be aggregated for CNA employee IDs denoted as being in a promoted position prior to the applicable rate period. CNA promotional hours available for the subsidy payment will be calculated as the LESSER OF the aggregated promotional hours OR total CNA hours on the CNA incentive template multiplied by 15%.
- Step 6: Calculate the total potential CNA promotional subsidy amount. Aggregated CNA promotion hours will be multiplied by the applicable per hour subsidized wage amount as denoted in Table 2.
- Step 7: Determine the Medicaid Percentage for the Facility. Medicaid percentage is calculated as Medicaid days divided by total occupied bed days.

Medicaid days shall be calculated quarterly based upon paid claims from the State's Medicaid Management Information System (MMIS) for a rolling 12-month period of historical data ending 9 months prior. For each new quarter beginning July 1, 2022, a facility's percentage of Medicaid bed days shall be paid Medicaid resident days per annum as determined by adding the number of Medicaid, Medicaid Managed Long Term Services & Supports (MLTSS) and MMAI days (inclusive of hospice and provisional days, if applicable) divided by the number of total occupied days found in the corresponding months of Long Term Care Provider Assessment Reports for the facility that are available to the Department.

For example, the July 1, 2022 rate period would utilize MMIS paid claims and Long Term Care Provider Assessment Report total occupied bed days from the period of October 1, 2020 – September 30, 2021 to determine Medicaid days and total occupied bed days respectively.

- Step 8: Calculate the total quarterly Medicaid CNA experience and promotional subsidy payment. Only the Medicaid proportion of the potential CNA experience and promotional subsidy amounts will be reimbursed by the Department. To calculate this amount, sum the total potential experience and promotional subsidy amounts from Step 4 and Step 5. Multiply this sum by the Medicaid percentage calculated in Step 7. This product is the quarterly Medicaid CNA experience and promotional subsidy payment.

Step 9: Determine the monthly Medicaid CNA experience and promotional subsidy payment. Divide the total quarterly Medicaid CNA subsidy from Step 8 by three.

Table 1 -- CNA Experience per Hour Subsidized Amounts

CNA Years of Experience	Per Medicaid Hour Subsidy Amount
< 1 Year	\$0.00
1 Year	\$1.50
2 Years	\$2.50
3 Years	\$3.50
4 Years	\$4.50
5 Years	\$5.50
6+ Years	\$6.50

Table 2 -- CNA Promotional per Hour Subsidized Amount

CNA Promotion	Per Medicaid Hour Subsidy Amount
Promoted Position Hrs.	\$1.50

PART IB
NURSING
COMPONENT LUMP
SUM PAYMENT
CALCULATION

QUALITY INCENTIVE
PAYMENT

July 1, 2022

July 1, 2022
NURSING COMPONENT LUMP SUM PAYMENT
CALCULATION OF THE QUALITY INCENTIVE

This part of the packet is for calculating the quarterly quality incentive payment effective for rate periods beginning on or after July 1, 2022. This payment provides for additional reimbursement to facilities that have demonstrated certain performance levels on a measure linked to specific resident outcomes. The goal of the payment is to provide financial resources to facilities to reward and incentivize the provision of quality of care and obtain more positive resident outcomes.

The quality incentive payment is initially to be based solely on each facility's Long Stay Quality Measures star rating published by Centers for Medicare and Medicaid Services (CMS) on <https://data.cms.gov/>. The statewide quality incentive payment pool will be no less than \$70 million dollars annually, or \$17.5 million dollars quarterly.

The payment will be made as a quarterly lump sum payment paid through the Medicaid fee-for-service (FFS) system and by each managed care and Medicare-Medicaid Alignment Initiative (MMAI) plan through a directed payment based on their proportion of facility specific Medicaid days.

The statutory formula described in Steps 1-7 below will determine a Medicaid per diem value for each Long Stay Quality measure star rating. The per diem dollar value calculated for each star rating (as defined in Step 7) for the implementing quarter of July through September of 2022 will serve as an initial floor until the Department alters the composition of quality measures used to distribute quality pool payments so that the pool is no longer distributed based solely on a facilities' Long Stay Quality measure star. Steps 8-10 describe the application of this initial payment floor.

To calculate your quality incentive payment, you will need to:

- Step 1: Determine the facility's Long Stay Quality Measure star rating as published by CMS on <https://data.com.gov/> for the most recent period.
- Step 2: Determine the facility's statutory quality weight. The weight varies dependent on the Long Stay Quality measure star rating. See Table 1 for applicable quality weights.
- Step 3: Determine facility Medicaid days. Facility Medicaid days shall be calculated quarterly based upon a rolling 12-month period of historical data ending 9 months prior for paid days from the State's Medicaid Management Information System (MMIS). For each new quarter beginning on or after July 1, 2022, a facility's Medicaid bed days shall be paid Medicaid resident days per annum as determined by adding the number of Medicaid, Medicaid Managed Long Term Services & Supports (MLTSS) and MMAI days (inclusive of hospice and provisional days, if applicable) divided by four.

For example, the July 1, 2022 rate period will utilize the sum of MMIS paid days from October 1, 2020 – September 30, 2021 divided by four.

- Step 4: Multiply Medicaid Days from Step 3 by the quality weight determined in Step 2, to determine facility quality weighted Medicaid days.
- Step 5: Divide the facility's quality weighted Medicaid days from Step 4, by the sum of quality weighted Medicaid days for all facilities statewide.
- Step 6: Multiply the quotient produced by Step 5 by the quarterly Quality Incentive Pool Value of \$17.5 million to determine the projected quality incentive payment for the facility

Steps 7 through 10 are to be applied unless and until the Department alters the composition of quality measures used to distribute quality pool payments so that the pool is no longer distributed based solely on a facilities' Long Stay Quality measure star.

- Step 7 Calculate the Dollar Value per Medicaid Day for each star rating. Sum all projected quality incentive payments from Step 6 for each star rating (separately) and divide by the sum of all corresponding Medicaid days for that star rating.
- Step 8: Compare the Dollar Value per Medicaid Day for each star rating as calculated in Step 7 to the values present in Table 2. If the Dollar Value per Medicaid Day for the current reimbursement period is less than the Dollar Value per Medicaid Day detailed Table 2 an adjustment to that star rating payment tier is necessary.
- Step 9: If an adjustment is determined necessary in Step 8 for the star rating payment tier, divide the Dollar Value per Medicaid Day from Table 2 for the applicable star rating by the Dollar Value per Medicaid Day calculated in Step 7 for corresponding star rating tier.
- Step 10: Multiply the quotient calculated in Step 9 by each facility's project quality incentive payment from Step 6 to determine the final facility quarterly quality incentive payment. This may result in the quality pool exceeding the \$17.5 million pool for the given quarter.

Table 1 -- Statutory Quality Weights

STAR rating	Statutory Weight applied to each Star Rating
0-1	0.00
2	0.75
3	1.50
4	2.50
5	3.50

Table 2 -- Star Rating Dollar Value per Medicaid Day Floor

STAR rating	Dollar Value per Medicaid Day Floor
0-1	-
2	\$1.79
3	\$3.59
4	\$5.98
5	\$8.37

PART II

SUPPORT

CALCULATION

FISCAL YEAR 2020

CALCULATION OF SUPPORT RATES

This part of the calculation packet is for calculating your support rate. The rate is based on adjusted costs from your latest cost report on file with the Department as of March 31, 2015. You need to make sure you have adjusted your cost report to reflect any changes made by the field auditors or by the Bureau of Health Finance during the desk audit process. Audit adjustments made to Schedule V of the cost report should be posted to Column 9 of Schedule V (unless otherwise indicated) and the revised totals in Column 10 should be used in calculating your reimbursement rate. Each facility has been notified by mail of any adjustments made by the Bureau of Health Finance.

Unless otherwise specified, all line numbers refer to Schedule V of your 2014 or 2013 or 2012 cost report.

INSTRUCTIONS AND CALCULATION STEPS

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your General Services and General Administration expenses. This is done by proration.

A. General Services:

1. Determine the proportion of general services wages to total wages.
2. Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.
3. Add the proportioned fringe amount to your total general service expenses to get your new total general services cost.

Take \$ _____ G.S. Wages (Column 1, Line 8)
 Divide by \$ _____ Total Wages (Column 1, Line 45)
 Equals _____ X \$ _____ Total Fringe (Col. 10, Line 22) = \$
 Plus Total General Services (Col. 10, Line 8) + \$
 NEW TOTAL GENERAL SERVICES COST = \$

B. General Administration:

1. Determine the proportion of General Administration wages to total wages.
2. Multiply the total lump sum fringe amount by this proportion to get the fringe amount for Gen. Adm.
3. Add the proportioned fringe amount to your total General Administration expenses.
4. Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration cost.

Take \$ _____ Gen. Adm. Wages (Column 1, Line 28)
Divide by \$ _____ Total Wages (Column 1, Line 45)
Equals _____ X \$ _____ Total Fringe (Col. 10, Line 22) = \$
Plus Total General Administration (Col. 10, Line 28) + \$
Minus Total Fringe (Column 10, Line 22) - \$
NEW TOTAL GENERAL ADMINISTRATION COST = \$

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation factors are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors that correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

(Beginning Month + Ending Month) divided by 2:

(Beginning Day + Ending Day) divided by 60.8: +

(Beginning Year + Ending Year) multiplied by 6: +

Sum of the three lines: =

Subtract from the sum: - 23707.00

Base Number: =

Drop the decimal fraction to get a whole number

Final Base Number: =

If you have a decimal fraction that is greater than 0.4 and you round the whole number upward, it will reduce your multiplier and, consequently, your rate. So be sure you drop, not round, decimal fractions in this final step.

EXAMPLE: This example shows how to calculate the base number for a cost report covering a year starting July 1, 2013 and ending June 30, 2014.

First, convert the dates to numbers: 7/1/2013 & 6/30/2014

Next, put the numbers in the formula:

Add 7 (Beg. Mo.) + 6 (End. Mo.), then divide by 2:	6.500000
Add 1 (Beg. Day) + 30 (End. Day), then divide by 60.8:	+ .509868
Add 2013 (Beg. Yr.) + 2014 (End. Yr.), then multiply by 6:	+24,162.00000
Sum of the three lines:	=24,169.00987
Subtract from the sum:	- 23,707.00000
Base Number:	= 462.00987
Drop Decimal Fraction to get Final Base Number:	= 462

B. Select the Appropriate Inflation Multipliers

Refer to Table I, Inflation Multipliers, and find the multipliers that correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

Using the example above, the Inflation Multipliers from Table One which correspond with the base number 462 are 1.0425 for General Services and 1.0436 for General Administration.

C. Apply Inflation Multipliers to Update Cost

1. Multiply your New Total General Services Cost (from Step I,A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I, A)	\$	
General Services Multiplier (Step II, B)	X	
UPDATED GENERAL SERVICES COST =		\$

2. Multiply your New Total General Administration Cost (from Step I, B) by the appropriate multiplier from Table I:

New Total General Administration Cost	\$	
(Step I,B)		
General Administration Multiplier	X	

(Step II,B)
 UPDATED GENERAL ADMINISTRATION COST = \$

3. Total your updated Support Costs (1 and 2).

Updated General Services Costs (1) \$
 Updated General Administration Costs (2) + \$

TOTAL UPDATED SUPPORT COSTS = \$

STEP III Convert Your Total Updated Support Costs (C, 3 above) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

- A. If the occupancy (Cost Report, page 2, Schedule III-C) is equal to or above 93%, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Take Total Support Costs (Step II, C, 3 above): \$
 Divide by Total Patient Days (Cost Report):
 Equals SUPPORT COSTS PER DIEM: \$

OR

- B. If the occupancy is below 93%, calculate 93% of the licensed bed days (cost report, page 2, Schedule III-A, column 4, line 7). Then subtract the total patient days (cost report, page 2, Schedule III-B, column 5, line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated support costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days: _____ (1)
 Multiplied by: X .93 (2)
 Equals Line (1) X Line (2): = _____ (3)
 Minus Total Patient Days: - _____ (4)
 Difference, line (3) minus line (4): = _____ (5)
 One-third of Difference, line (5) times 1/3: = _____ (6)
 Plus Total Patient Days, line (4): + _____ (7)
 Adjusted Occupancy, line (6) plus line (7): = _____ (8)

Take Total Support Costs (Step II, C, 3 above): \$
 Divide by Adjusted Occupancy, line (8):
 Equals SUPPORT COSTS PER DIEM: = \$

STEP IV Calculate Your Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by rate area are listed in Table II, Support Rate Percentiles by rate area. Use one of the three procedures below and refer to Table II to calculate your support rate.

- A. If your support costs per diem from Step III is equal to or greater than the 75th percentile for your rate area, then your support rate is the 75th percentile rate listed in Table II.

- B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your rate area, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

Take the 75 th Percentile Rate for your rate area: (Table II)	\$ _____ (1)
Subtract your Support Costs Per Diem: (Step III)	- \$ _____ (2)
Equals the Difference, Line (1) - Line (2):	= \$ _____ (3)
Multiply the Difference by .50, Line (3) X .50:	X .50 (4)
Equals One-half the Difference:	= \$ _____ (5)
Add your Support Costs Per Diem (Step III):	+ \$ _____ (6)
Equals your Support Rate, Line (5) + Line (6): (7)	= \$ _____

- C. If your support cost per diem from Step III is below the 35th percentile for your rate area, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50% of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each rate area is listed in Table II. Use the following procedure to calculate your rate:

Take the 75 th Percentile Rate for your rate area: (Table II)	\$ _____ (1)
Subtract your Support Costs Per Diem: (Step III)	- \$ _____ (2)
Equals the Difference, Line (1) - Line (2):	= \$ _____ (3)
Multiply the Difference by .50, Line (3) X .50:	X .50 (4)
Equals One-half the Difference:	= \$ _____ (5)
Compare one-half the difference, Line (5),	

to the profit ceiling for your rate area in
Table II, and

Enter the Lower of the Two Amounts: = \$ _____ (6)
Add your Support Costs Per Diem (Step III): + \$ _____ (7)
Equals your Support Rate, Line (6) + Line (7): = \$ _____
(8)

Your Calculated SUPPORTRATE from
A, B, or C above: \$ _____

D. Enter your 06/30/2019 support rate from prior rate notification \$ _____

E. Per 90.8% of your Calculated Support Rate from above \$ _____

F. Greater of D. or E. above \$ _____

G. 3.45% of F above \$ _____

H. 7/1/19 Support Rate per Public Act 101-0010 F. + G. above \$ _____

Table I - - Inflation Multipliers

BASE NUMBER	GENERAL SERVICES MULTIPLIER	GENERAL ADMINISTRATION MULTIPLIER	BASE NUMBER	GENERAL SERVICES MULTIPLIER	GENERAL ADMINISTRATION MULTIPLIER
437	1.0744	1.0691	462	1.0425	1.0436
438	1.0732	1.0683	463	1.0418	1.0434
439	1.0724	1.0680	464	1.0411	1.0432
440	1.0717	1.0678	465	1.0391	1.0411
441	1.0731	1.0709	466	1.0384	1.0409
442	1.0724	1.0706	467	1.0377	1.0406
443	1.0716	1.0704	468	1.0315	1.0323
444	1.0691	1.0675	469	1.0308	1.0321
445	1.0684	1.0673	470	1.0302	1.0319
446	1.0676	1.0671	471	1.0278	1.0293
447	1.0638	1.0623	472	1.0271	1.0290
448	1.0630	1.0620	473	1.0264	1.0288
449	1.0623	1.0618	474	1.0224	1.0238
450	1.0589	1.0577	475	1.0218	1.0235
451	1.0582	1.0575	476	1.0211	1.0233
452	1.0574	1.0573	477	1.0184	1.0201
453	1.0572	1.0577	478	1.0177	1.0199
454	1.0564	1.0575	478	1.0170	1.0197
455	1.0557	1.0572	480	1.0103	1.0106
456	1.0480	1.0468	481	1.0096	1.0104
457	1.0473	1.0466	482	1.0090	1.0102
458	1.0466	1.0463	483	1.0027	1.0018
459	1.0459	1.0461	484	1.0021	1.0016
460	1.0452	1.0459	485	1.0014	1.0014

Table II - - SUPPORT RATE PERCENTILES BY RATE AREA

HSA	RATE AREA	75TH PERCENTILE	35TH PERCENTILE	BELOW 35TH PROFIT CEILING
1 & 10	Northwest	67.00	53.39	6.855
2 & 4	Central	65.97	52.67	6.700
3	West Central	59.58	49.68	5.000
5	South	55.27	46.55	4.410
6, 7 & 8	Chicago	75.83	53.56	11.185
9	S. Suburbs	75.68	54.51	10.635
11	St. Louis	59.56	49.56	5.050