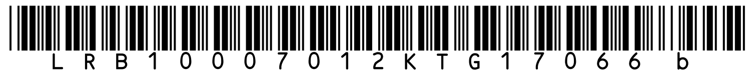
SB1559



LRB100 07012 KTG 17066 b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB1559

Introduced 2/9/2017, by Sen. Heather A. Steans - Dale A. Righter

SYNOPSIS AS INTRODUCED:

See Index

Amends the Medical Assistance Article of the Illinois Public Aid Code. In provisions concerning payment rates for nursing facilities, provides that facility-specific staffing levels and wages paid (rather than regional wage adjusters based on the Health Service Areas (HSA) groupings and adjusters in effect on April 30, 2012) shall be one of the factors in determining the new nursing services reimbursement methodology utilizing the RUG-IV 48 grouper model. Sets forth the calculation of the facility-specific RUG-IV nursing component per diem rate for dates of service beginning July 1, 2017. Provides that certain staffing and wage adjusters must be updated each quarter using the staffing hours and wage data from Payroll Benefit Journal data collected by the Centers for Medicare and Medicaid Services for the same time period of Minimum Date Set data used to calculate the RUG-IV acuity case weight. Sets forth how to calculate each facility's "total per resident per day staffing wage cost". Provides that the levels used to assign certain staffing and wage adjusters shall be calculated using the staffing ratios required under the Nursing Home Care Act multiplied by the Illinois mean hourly wage for the equivalent occupational code and title assigned by the U.S. Bureau of Labor Statistics and reported in the May 2014 State Occupational Employment and Wage Estimates for Illinois. Provides that beginning July 1, 2017 and quarterly thereafter, the Department of Healthcare and Family Services may adjust, by administrative rule and within certain parameters established under the Code, a specific staffing and wage adjuster described in the Code for the purpose of keeping liability created by the facility-specific RUG-IV nursing component per diem rates stable. Permits the Department to adopt rules to implement these provisions. Effective immediately.

LRB100 07012 KTG 17066 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Findings. The General Assembly finds as follows:

(1) It is in the best interest of the citizens of Illinois to review and update Medicaid payment methodologies to ensure the best use of public resources.

(2) The intent of the $6.07 tax per occupied bed day imposed by Public Act 96-1530 was to pay for increased staffing under Public Act 96-1372.

(3) Many nursing homes are still staffed below the legal level required under Section 3-202.05 of the Nursing Home Care Act.

(4) Some low-staffed homes have gained from the higher Medicaid rates but have not increased staffing.

(5) Policy research has noted the significant positive relationship between nursing home staffing levels and quality of care.

(6) The State of Illinois desires to pay for value and quality not just volume.

(7) The use of regional wage adjusters rewards or penalizes nursing homes solely on location and does not account for staffing levels or actual wages paid.

1 Section 5. The Illinois Public Aid Code is amended by
2 changing Section 5-5.2 as follows:

3 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)
4 Sec. 5-5.2. Payment.
5 (a) All nursing facilities that are grouped pursuant to
6 Section 5-5.1 of this Act shall receive the same rate of
7 payment for similar services.
8 (b) It shall be a matter of State policy that the Illinois
9 Department shall utilize a uniform billing cycle throughout the
10 State for the long-term care providers.
11 (c) Notwithstanding any other provisions of this Code, the
12 methodologies for reimbursement of nursing services as
13 provided under this Article shall no longer be applicable for
14 bills payable for nursing services rendered on or after a new
15 reimbursement system based on the Resource Utilization Groups
16 (RUGs) has been fully operationalized, which shall take effect
17 for services provided on or after January 1, 2014.
18 (d) The new nursing services reimbursement methodology
19 utilizing RUG-IV 48 grouper model, which shall be referred to
20 as the RUGs reimbursement system, taking effect January 1,
21 2014, shall be based on the following:
22 (1) The methodology shall be resident-driven,
23 facility-specific, and cost-based.
24 (2) Costs shall be annually rebased and case mix index
25 quarterly updated. The nursing services methodology will

be assigned to the 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) as present on the last day of the second quarter preceding the rate period based upon the Assessment Reference Date of the Minimum Data Set (MDS).

(3) Facility-specific staffing levels and wages paid. ~~Regional wage adjustors based on the Health Service Areas (HSA) groupings and adjusters in effect on April 30, 2012 shall be included.~~

(4) Case mix index shall be assigned to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study in effect on July 1, 2013, utilizing an index maximization approach.

(5) The pool of funds available for distribution by case mix and the base facility rate shall be determined using the formula contained in subsection (d-1).

(d-1) Calculation of base year Statewide RUG-IV nursing base per diem rate, for dates of service beginning January 1, 2014 through June 30, 2017.

(1) Base rate spending pool shall be:

(A) The base year resident days which are calculated by multiplying the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) by 365.

(B) Each facility's nursing component per diem in

1 effect on July 1, 2012 shall be multiplied by
2 subsection (A).
3 (C) Thirteen million is added to the product of
4 subparagraph (A) and subparagraph (B) to adjust for the
5 exclusion of nursing homes defined in paragraph (5).
6 (2) For each nursing home with Medicaid residents as
7 indicated by the MDS data defined in paragraph (4),
8 weighted days adjusted for case mix and regional wage
9 adjustment shall be calculated. For each home this
10 calculation is the product of:
11 (A) Base year resident days as calculated in
12 subparagraph (A) of paragraph (1).
13 (B) The nursing home's regional wage adjustor
14 based on the Health Service Areas (HSA) groupings and
15 adjustors in effect on April 30, 2012.
16 (C) Facility weighted case mix which is the number
17 of Medicaid residents as indicated by the MDS data
18 defined in paragraph (4) multiplied by the associated
19 case weight for the RUG-IV 48 grouper model using
20 standard RUG-IV procedures for index maximization.
21 (D) The sum of the products calculated for each
22 nursing home in subparagraphs (A) through (C) above
23 shall be the base year case mix, rate adjusted weighted
24 days.
25 (3) The Statewide RUG-IV nursing base per diem rate:
26 (A) on January 1, 2014 shall be the quotient of the

paragraph (1) divided by the sum calculated under subparagraph (D) of paragraph (2); and

(B) on and after July 1, 2014, shall be the amount calculated under subparagraph (A) of this paragraph (3) plus $1.76.

(4) Minimum Data Set (MDS) comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate.

(5) Nursing facilities designated as of July 1, 2012 by the Department as "Institutions for Mental Disease" shall be excluded from all calculations under this subsection. The data from these facilities shall not be used in the computations described in paragraphs (1) through (4) above to establish the base rate.

(e) Beginning July 1, 2014, the Department shall allocate funding in the amount up to $10,000,000 for per diem add-ons to the RUGS methodology for dates of service on and after July 1, 2014:

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

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

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014 through June 30, 2017, the RUG-IV nursing component per diem

1 for a nursing home shall be the product of the statewide RUG-IV
2 nursing base per diem rate, the facility average case mix
3 index, and the regional wage adjustor. Transition rates for
4 services provided between January 1, 2014 and December 31, 2014
5 shall be as follows:

6 (1) The transition RUG-IV per diem nursing rate for
7 nursing homes whose rate calculated in this subsection
8 (e-2) is greater than the nursing component rate in effect
9 July 1, 2012 shall be paid the sum of:

10 (A) The nursing component rate in effect July 1,
11 2012; plus

12 (B) The difference of the RUG-IV nursing component
13 per diem calculated for the current quarter minus the
14 nursing component rate in effect July 1, 2012
15 multiplied by 0.88.

16 (2) The transition RUG-IV per diem nursing rate for
17 nursing homes whose rate calculated in this subsection
18 (e-2) is less than the nursing component rate in effect
19 July 1, 2012 shall be paid the sum of:

20 (A) The nursing component rate in effect July 1,
21 2012; plus

22 (B) The difference of the RUG-IV nursing component
23 per diem calculated for the current quarter minus the
24 nursing component rate in effect July 1, 2012
25 multiplied by 0.13.

26 <u>(e-3) Calculation of facility-specific RUG-IV nursing</u>

component per diem rate for dates of service beginning July 1, 2017.

(1) The facility-specific RUG-IV nursing component per diem rate must be the product of:

(A) The Statewide RUG-IV base rate of $85.25.

(B) The staffing and wage adjuster which is assigned per facility based on the facility's specific total per resident per day staffing wage cost as defined in paragraph (2) of this subsection. For levels defined in paragraph (3) of this subsection, the staffing wage adjuster is:

(i) 0.80 for a facility with a total per resident per day staffing wage cost less than level 1, or a facility whose staffing level is below the intermediate care minimum required under Section 3-202.05 of the Nursing Home Care Act even if the facility has a total per resident per day staffing wage cost greater than or equal to level 1;

(ii) 1.22 for a facility with a total per resident per day staffing wage cost greater than or equal to level 1 but less than level 2;

(iii) 1.42 for a facility with a total per resident per day staffing wage cost greater than or equal to level 2 but less than level 3;

(iv) 1.45 for a facility with a total per resident per day staffing wage cost greater than or

1 equal to level 3; or
2 (v) 0.80 for a facility without data necessary
3 to calculate the facility's specific total per
4 resident per day staffing wage cost as defined in
5 paragraph (2) of this subsection.
6 (C) The facility weighted case mix, which is the
7 number of Medicaid residents as indicated by the
8 Minimum Data Set (MDS) data defined in paragraph (4) of
9 this subsection multiplied by the associated case
10 weight for the RUG-IV 48 grouper model using standard
11 RUG-IV procedures for index maximization.
12 (D) The ratio of actual staffing hours to total
13 expected staffing hours adjuster which is assigned
14 based on each facility's ratio as defined in paragraph
15 (5) of this subsection. The facilities are divided into
16 4 quartiles sorted from lowest to highest based on the
17 facility's ratio. The quartile with the lowest ratios
18 is quartile 1 and the quartile with the highest ratios
19 is quartile 4 with quartile 2 and quartile 3 assigned
20 based on the ratios in those quartiles in relation to
21 lowest and highest quartiles. Facilities without
22 reported data are assigned to quartile 3. The quartiles
23 are calculated quarterly during regular rate updates.
24 The adjuster for each quartile is as follows:
25 (i) 0.65 for facilities in quartile 1;
26 (ii) the ratio defined in paragraph (5) of this

1 subsection for facilities in quartile 2 and 3; or
2 (iii) 1.00 for facilities in quartile 4.
3 (2) The staffing and wage adjuster under subparagraph
4 (B) of paragraph (1) of this subsection must be updated
5 each quarter using the staffing hours and wage data from
6 Payroll Benefit Journal data collected by the Centers for
7 Medicare and Medicaid Services for the same time period of
8 MDS data used to calculate the RUG-IV acuity case weight.
9 For the purposes of this Section, each facility's "total
10 per resident per day staffing wage cost" is calculated by
11 summing:
12 (A) The product of registered nurses' hours worked
13 per resident day multiplied by the reported hourly
14 wage. For the Director of Nursing only the number of
15 hours allowed under Section 3-202.05 of the Nursing
16 Home Care Act for the calculation of staffing ratios
17 may be included; plus
18 (B) The product of licensed practical nurses'
19 worked hours per resident day multiplied by the
20 reported hourly wage; plus
21 (C) The product of certified nurse assistants'
22 hours worked per resident day multiplied by the
23 reported hourly wage; plus
24 (D) For all other staff considered direct care
25 staff under staffing ratios described in Section
26 3-202.05 of the Nursing Home Care Act, the product of

1 each remaining direct care staff type hours worked per
2 resident day multiplied by the reported hourly wage for
3 the direct care staff category at the same levels
4 allowed under the staffing ratios under Section
5 3-202.05 of the Nursing Home Care Act.
6 (3) The levels used to assign the staffing and wage
7 adjuster under subparagraph (B) of paragraph (1) of this
8 subsection shall be calculated using the staffing ratios
9 required under Section 3-202.05 of the Nursing Home Care
10 Act multiplied by the Illinois mean hourly wage for the
11 equivalent occupational code and title assigned by the U.S.
12 Bureau of Labor Statistics and reported in the May 2014
13 State Occupational Employment and Wage Estimates for
14 Illinois. The Department may, as established by rule, use
15 more current data from the same data set when made
16 available. The levels are:
17 (A) Level 1 is equal to the sum of:
18 (i) The product of 10% of the minimum staffing
19 hours per resident day for intermediate care under
20 Section 3-202.05 of the Nursing Home Care Act
21 multiplied by the Illinois mean hourly wage for
22 registered nurses occupation code 29-1141 from the
23 U.S. Bureau of Labor Statistics data set described
24 in paragraph (3) of this subsection; plus
25 (ii) The product of 15% of the minimum staffing
26 hours per resident day for intermediate care under

1 Section 3-202.05 of the Nursing Home Care Act
2 multiplied by the Illinois mean hourly wage for
3 licensed practical nurses occupation code 29-2061
4 from the U.S. Bureau of Labor Statistics data set
5 described in paragraph (3) of this subsection;
6 plus
7 (iii) The product of 75% of the minimum
8 staffing hours per resident day for intermediate
9 care under Section 3-202.05 of the Nursing Home
10 Care Act multiplied by the Illinois mean hourly
11 wage for nursing assistants occupation code
12 31-1014 from the U.S. Bureau of Labor Statistics
13 data set described in paragraph (3) of this
14 subsection.
15 (B) Level 2 is equal to the sum of:
16 (i) The product of 10% of the minimum staffing
17 hours per resident day for skilled care under
18 Section 3-202.05 of the Nursing Home Care Act
19 multiplied by the Illinois mean hourly wage for
20 registered nurses occupation code 29-1141 from the
21 U.S. Bureau of Labor Statistics data set described
22 in paragraph (3) of this subsection; plus
23 (ii) The product of 15% of the minimum staffing
24 hours per resident day for skilled care under
25 Section 3-202.05 of the Nursing Home Care Act
26 multiplied by the Illinois mean hourly wage for

1 licensed practical nurses occupation code 29-2061
2 from the U.S. Bureau of Labor Statistics set
3 described in paragraph (3) of this subsection;
4 plus
5 (iii) The product of 75% of the minimum
6 staffing hours per resident day for skilled care
7 under Section 3-202.05 of the Nursing Home Care Act
8 multiplied by the Illinois mean hourly wage for
9 nursing assistants occupation code 31-1014 from
10 the U.S. Bureau of Labor Statistics data set
11 described in paragraph (3) of this subsection.
12 (C) Level 3 is equal to the sum of:
13 (i) The product of .84 staffing hours per
14 resident day multiplied by the Illinois mean
15 hourly wage for registered nurses occupation code
16 29-1141 from the U.S. Bureau of Labor Statistics
17 data set described in paragraph (3) of this
18 subsection; plus
19 (ii) The product of .84 staffing hours per
20 resident day multiplied by the Illinois mean
21 hourly wage for licensed practical nurses
22 occupation code 29-2061 from the U.S. Bureau of
23 Labor Statistics data set described in paragraph
24 (3) of this subsection; plus
25 (iii) The product of 2.46 staffing hours per
26 resident day multiplied by the Illinois mean

hourly wage for nursing assistants occupation code 31-1014 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection.

(4) Minimum Data Set comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the rate.

(5) The facility-specific total ratio of actual staffing hours to total expected staffing hours for the assigned resident specific case weight must be updated each quarter using the staffing hours and wage data from Payroll Benefit Journal data collected by the Centers for Medicare and Medicaid Services for the same time period of MDS data used to calculate the RUG-IV acuity case weight. For each facility the Department must calculate the total hours worked per resident day for direct care staff allowed by the staffing ratios under Section 3-202.05 of the Nursing Home Care Act and divide that value by the sum of staffing hours per resident day assigned to each resident based on the sum of the Resident Specific Time and Direct Non-Resident Specific Time for the resident's RUG-IV group. This is the same methodology for the Medicare 5-star rating program calculation of the expected staffing hours per resident day used by the Centers for Medicare and Medicaid Services, except that the Centers for Medicare and Medicaid Services uses RUG-III groupings.

1 (6) If the Payroll Benefit Journal data collected by
2 the Centers for Medicare and Medicaid Services is not
3 available, the Department must use the most recent cost
4 reporting data reported to the Department and the most
5 recent survey data posted to the Centers for Medicare and
6 Medicaid Services' Nursing Home Compare website. The
7 Department must use the Payroll Benefit Journal data
8 collected by the Centers for Medicare and Medicaid Services
9 once the data is available.
10 (e-4) Budget stability beginning July 1, 2017.
11 (1) Beginning July 1, 2017 and quarterly thereafter,
12 the Department may adjust, by administrative rule and
13 within the parameters established under this subsection
14 (e-4), the staffing and wage adjuster described in
15 subparagraph (B) of paragraph (1) of subsection (e-3) and
16 the ratio of actual staffing hours to the total expected
17 staffing hours adjuster described in subparagraph (D) of
18 paragraph (1) of subsection (e-3) for the purpose of
19 keeping liability created by the facility-specific RUG-IV
20 nursing component per diem rates stable as defined in
21 paragraph (2) and paragraph (3) of this subsection (e-4).
22 (2) Budget stability for facility-specific RUG-IV
23 nursing component per diem rates effective July 1, 2017
24 through June 30, 2019. If the aggregate budget stability
25 ratio calculated under paragraph (4) of this subsection is
26 greater than 0.96, then the Department must adjust one or

1 both of the adjusters specified in paragraph (1) of this
2 subsection in order to decrease the ratio to no less than
3 0.96.
4 (3) Budget stability for facility-specific RUG-IV
5 nursing component per diem rates effective July 1, 2019 and
6 quarterly thereafter. If the aggregate budget stability
7 ratio calculated under paragraph (4) of this subsection is
8 between 0.98 and 1.00, the Department must not make any
9 adjustments. If the aggregate budget stability ratio
10 calculated under paragraph (4) of this subsection is less
11 than 0.98, then the Department must adjust one or both of
12 the adjusters specified in paragraph (1) of this subsection
13 in order to increase the ratio to at least 0.98. If the
14 aggregate budget stability ratio calculated under
15 paragraph (4) of this subsection is greater than 1.00, then
16 the Department must adjust one or both of the adjusters
17 specified in paragraph (1) of this subsection in order to
18 decrease the ratio to at least 1.00, but no less than 1.00.
19 (4) For the purposes of this Section, the aggregate
20 budget stability ratio calculated with the numerator
21 described in subparagraph (A) of this paragraph (4) divided
22 by the denominator described in subparagraph (B) of this
23 paragraph (4) is as follows:
24 (A) Numerator equal to the sum of the following
25 products:
26 (i) the product of the number of Medicaid

residents in each nursing home as indicated in the MDS data defined in paragraph (4) of subsection (e-3) multiplied by 365; then multiplied by

(ii) each nursing home's specific rate under paragraph (1) of subsection (e-3). This rate does not include the per diem add-ons defined in subsection (e) of this Section.

(B) Denominator equal to the sum of the following products:

(i) the product of the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) of subsection (e-3) multiplied by 365; then multiplied by

(ii) each nursing home's specific rate effective July 1, 2015 under subsection (e-2) as adjusted by any past or future MDS validation reviews performed by the Department. This rate does not include the per diem add-ons defined in subsection (e) of this Section.

(5) If adjustments are necessary under this subsection (e-4), the staffing and wage adjuster described in subparagraph (B) of paragraph (1) of subsection (e-3) must be adjusted within the following parameters:

(A) the adjuster for facilities with a total per resident per day staffing wage cost less than level 1 must never be greater than 0.80;

1 (B) the adjuster for facilities with a total per
2 resident per day staffing wage cost less than level 1
3 must be lower than the adjusters for the other levels;
4 (C) the adjuster for facilities with a total per
5 resident per day staffing wage cost less than level 1
6 must generate an aggregate cost coverage for nursing
7 homes qualifying for that adjuster less than or equal
8 to 70% using the most recent cost data from cost
9 reports filed with the Department. The cost coverage
10 for the nursing homes qualifying for that adjuster must
11 have the lowest cost coverage as compared to the other
12 3 groups;
13 (D) the adjusters for the middle 2 levels must
14 generate the best possible aggregate cost coverage for
15 nursing homes qualifying for those adjusters of all the
16 adjusters using the most recent cost data from cost
17 reports filed with the Department; and
18 (E) the adjuster for facilities with a total per
19 resident per day staffing wage cost greater than level
20 4 must generate an aggregate cost coverage for nursing
21 homes qualifying for that adjuster less than or equal
22 to 80% using the most recent cost data from cost
23 reports filed with the Department.
24 (F) Any limitations in this paragraph (5) based on
25 cost coverage must use the most recent cost data from
26 cost reports filed with the Department and must be

1 calculated after any adjustments have been made to the
2 ratio of actual staffing hours to total expected
3 staffing hours adjuster described in subparagraph (D)
4 of paragraph (1) of subsection (e-3) and limited by
5 paragraph (6) of this subsection (e-4).
6 (6) If adjustments are necessary under this subsection
7 (e-4), the ratio of actual staffing hours to total expected
8 staffing hours adjuster described in subparagraph (D) of
9 paragraph (1) of subsection (e-3) must be adjusted within
10 the following parameters:
11 (A) the adjuster for quartile 4 which has the best
12 acuity based staffing ratio must never be less than
13 1.00;
14 (B) the adjuster for quartile 1 must be the
15 smallest of all 4 quartile adjusters and must never be
16 greater than 0.65;
17 (C) the Department may set a specific adjuster for
18 quartile 2 and quartile 3 as opposed to the
19 facility-specific ratio defined in paragraph (5) of
20 subsection (e-3) which is allowed under subparagraph
21 (D) of paragraph (1) of subsection (e-3). If the
22 Department sets a specific adjuster for quartile 2 or
23 quartile 3, then the adjuster for quartile 3 must not
24 be greater than the adjuster for quartile 4 or less
25 than the adjuster for quartile 2. The adjuster for
26 quartile 2 must not be greater than the adjuster for

1 quartile 3 or less than the adjuster for quartile 1;
2 and
3 (D) no quartile may have an adjuster greater than
4 1.00.
5 (7) For the purposes of this Section, cost coverage for
6 a facility is the facility-specific RUG-IV nursing
7 component per diem rate divided by the healthcare program
8 cost per day. The healthcare program cost per day is
9 calculated using data from cost reports submitted to the
10 Department as required under this Code and the Department's
11 administrative rules. The Department may update the cost
12 report references in this paragraph by administrative rule
13 should the Department's cost report be altered, as long as
14 the updated references result in identification of the
15 identical or equivalent data and does not materially change
16 the resulting calculations. If the Department has made
17 changes from an audit, the Department may use column 10
18 instead of column 8 of the respective cost report lines
19 cited in this paragraph (7) if the information is made
20 publicly available at the time of making any calculations
21 required in this Section. The healthcare program cost per
22 day is the quotient of:
23 (A) the sum of the following costs as reported on
24 schedule V. of the Department's cost report;
25 (i) the total adjusted health care and
26 programs costs as reported on line 16 column 8;

plus

(ii) the total adjusted provider participation fee costs as reported on line 42 column 8; plus

(iii) the total allocated cost of employee benefits for health care employees calculated as the total adjusted health care and programs salary and wage costs as reported on line 16 column 1 divided by the product of the grand total salary and wages as reported on line 45 column 1 multiplied by the total adjusted employee benefits and payroll taxes as report on line 22 column 8;

(B) divided by the total patient days reported on schedule III line 14 column 5 of the Department's cost report.

(f) Notwithstanding any other provision of this Code, on and after July 1, 2012, reimbursement rates associated with the nursing or support components of the current nursing facility rate methodology shall not increase beyond the level effective May 1, 2011 until a new reimbursement system based on the RUGs IV 48 grouper model has been fully operationalized.

(g) Notwithstanding any other provision of this Code, on and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease", rates effective May 1, 2011 shall be adjusted as follows:

(1) Individual nursing rates for residents classified

in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter ending March 31, 2012 shall be reduced by 10%;

(2) Individual nursing rates for residents classified in all other RUG IV groups shall be reduced by 1.0%;

(3) Facility rates for the capital and support components shall be reduced by 1.7%.

(h) Notwithstanding any other provision of this Code, on and after July 1, 2012, nursing facilities designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease" and "Institutions for Mental Disease" that are facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall have the nursing, socio-developmental, capital, and support components of their reimbursement rate effective May 1, 2011 reduced in total by 2.7%.

(i) On and after July 1, 2014, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2014 increased by 8.17%.

(j) The Department may adopt rules in accordance with the Illinois Administrative Procedure Act to implement this Section. However, the requirements under this Section must be implemented by the Department even if the Department has not adopted rules by the implementation date of July 1, 2017.

(k) The new rates under the reimbursement methodology

1 created by this amendatory Act of the 100th General Assembly
2 shall not be paid until approved by the Centers for Medicare
3 and Medicaid Services.
4 (Source: P.A. 98-104, Article 6, Section 6-240, eff. 7-22-13;
5 98-104, Article 11, Section 11-35, eff. 7-22-13; 98-651, eff.
6 6-16-14; 98-727, eff. 7-16-14; 98-756, eff. 7-16-14; 99-78,
7 eff. 7-20-15.)

8 Section 99. Effective date. This Act takes effect upon
9 becoming law.

1 INDEX

2 Statutes amended in order of appearance

3 305 ILCS 5/5-5.2 from Ch. 23, par. 5-5.2