Sen. Ann Gillespie

Filed: 11/29/2022

AMENDMENT TO HOUSE BILL 4846

AMENDMENT NO. _____. Amend House Bill 4846 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.35 as follows:

(5 ILCS 100/5-45.35 new)

Sec. 5-45.35. Emergency rulemaking; rural emergency hospitals. To provide for the expeditious and timely implementation of this amendatory Act of the 102nd General Assembly, emergency rules implementing the inclusion of rural emergency hospitals in the definition of "hospital" in Section 3 of the Hospital Licensing Act may be adopted in accordance with Section 5-45 by the Department of Public Health. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed one year after the effective date of this amendatory Act of the 102nd General Assembly.

Section 10. The Hospital Licensing Act is amended by changing Section 3 as follows:

(210 ILCS 85/3)

Sec. 3. As used in this Act:

(A) "Hospital" means any institution, place, building, buildings on a campus, or agency, public or private, whether organized for profit or not, devoted primarily to the maintenance and operation of facilities for the diagnosis and treatment or care of 2 or more unrelated persons admitted for overnight stay or longer in order to obtain medical, including obstetric, psychiatric and nursing, care of illness, disease, injury, infirmity, or deformity.

The term "hospital", without regard to length of stay, shall also include:

(a) any facility which is devoted primarily to providing psychiatric and related services and programs for the diagnosis and treatment or care of 2 or more unrelated persons suffering from emotional or nervous diseases;

(b) all places where pregnant females are received, cared for, or treated during delivery irrespective of the number of patients received; and ~~.~~

(c) on and after January 1, 2023, a rural emergency hospital, as that term is defined under subsection (kkk)(2) of Section 1861 of the federal Social Security Act; to provide for the expeditious and timely implementation of this amendatory Act of the 102nd General Assembly, emergency rules to implement the changes made to the definition of "hospital" by this amendatory Act of the 102nd General Assembly may be adopted by the Department subject to the provisions of Section 5-45 of the Illinois Administrative Procedure Act.

The term "hospital" includes general and specialized hospitals, tuberculosis sanitaria, mental or psychiatric hospitals and sanitaria, and includes maternity homes, lying-in homes, and homes for unwed mothers in which care is given during delivery.

The term "hospital" does not include:

(1) any person or institution required to be licensed pursuant to the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act;

(2) hospitalization or care facilities maintained by the State or any department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitalization or care facilities under its management and control;

(3) hospitalization or care facilities maintained by

the federal government or agencies thereof;

(4) hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

(5) any person or facility required to be licensed pursuant to the Substance Use Disorder Act;

(6) any facility operated solely by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any well-recognized church or religious denomination;

(7) an Alzheimer's disease management center alternative health care model licensed under the Alternative Health Care Delivery Act; or

(8) any veterinary hospital or clinic operated by a veterinarian or veterinarians licensed under the Veterinary Medicine and Surgery Practice Act of 2004 or maintained by a State-supported or publicly funded university or college.

(B) "Person" means the State, and any political subdivision or municipal corporation, individual, firm, partnership, corporation, company, association, or joint stock association, or the legal successor thereof.

(C) "Department" means the Department of Public Health of the State of Illinois.

(D) "Director" means the Director of Public Health of the

State of Illinois.

(E) "Perinatal" means the period of time between the conception of an infant and the end of the first month after birth.

(F) "Federally designated organ procurement agency" means the organ procurement agency designated by the Secretary of the U.S. Department of Health and Human Services for the service area in which a hospital is located; except that in the case of a hospital located in a county adjacent to Wisconsin which currently contracts with an organ procurement agency located in Wisconsin that is not the organ procurement agency designated by the U.S. Secretary of Health and Human Services for the service area in which the hospital is located, if the hospital applies for a waiver pursuant to 42 U.S.C. ~~USC~~ 1320b-8(a), it may designate an organ procurement agency located in Wisconsin to be thereafter deemed its federally designated organ procurement agency for the purposes of this Act.

(G) "Tissue bank" means any facility or program operating in Illinois that is certified by the American Association of Tissue Banks or the Eye Bank Association of America and is involved in procuring, furnishing, donating, or distributing corneas, bones, or other human tissue for the purpose of injecting, transfusing, or transplanting any of them into the human body. "Tissue bank" does not include a licensed blood bank. For the purposes of this Act, "tissue" does not include

organs.

(H) "Campus", as this term ~~terms~~ applies to operations, has the same meaning as the term "campus" as set forth in federal Medicare regulations, 42 CFR 413.65.

(Source: P.A. 99-180, eff. 7-29-15; 100-759, eff. 1-1-19.)

Section 15. The Behavior Analyst Licensing Act is amended by changing Sections 30, 35, and 150 as follows:

(225 ILCS 6/30)

(Section scheduled to be repealed on January 1, 2028)

Sec. 30. Qualifications for behavior analyst license.

(a) A person qualifies to be licensed as a behavior analyst if that person:

(1) has applied in writing or electronically on forms prescribed by the Department;

(2) is a graduate of a graduate level program in the field of behavior analysis or a related field with an equivalent course of study in behavior analysis approved by the Department from a regionally accredited university ~~approved by the Department~~;

(3) has completed at least 500 hours of supervision of behavior analysis, as defined by rule;

(4) has qualified for and passed the examination for the practice of behavior analysis as authorized by the Department; and

(5) has paid the required fees.

(b) The Department may issue a license to a certified behavior analyst seeking licensure as a licensed behavior analyst who (i) does not have the supervised experience as described in paragraph (3) of subsection (a), (ii) applies for licensure before July 1, 2028, and (iii) has completed all of the following:

(1) has applied in writing or electronically on forms prescribed by the Department;

(2) is a graduate of a graduate level program in the field of behavior analysis from a regionally accredited university approved by the Department;

(3) submits evidence of certification by an appropriate national certifying body as determined by rule of the Department;

(4) has passed the examination for the practice of behavior analysis as authorized by the Department; and

(5) has paid the required fees.

(c) An applicant has 3 years after the date of application to complete the application process. If the process has not been completed in 3 years, the application shall be denied, the fee shall be forfeited, and the applicant must reapply and meet the requirements in effect at the time of reapplication.

(d) Each applicant for licensure as <u>a</u> ~~an~~ behavior analyst shall have his or her fingerprints submitted to the Illinois State Police in an electronic format that complies with the

form and manner for requesting and furnishing criminal history record information as prescribed by the Illinois State Police. These fingerprints shall be transmitted through a live scan fingerprint vendor licensed by the Department. These fingerprints shall be checked against the Illinois State Police and Federal Bureau of Investigation criminal history record databases now and hereafter filed, including, but not limited to, civil, criminal, and latent fingerprint databases. The Illinois State Police shall charge a fee for conducting the criminal history records check, which shall be deposited in the State Police Services Fund and shall not exceed the actual cost of the records check. The Illinois State Police shall furnish, pursuant to positive identification, records of Illinois convictions as prescribed under the Illinois Uniform Conviction Information Act and shall forward the national criminal history record information to the Department.

(Source: P.A. 102-953, eff. 5-27-22; revised 8-19-22.)

(225 ILCS 6/35)

(Section scheduled to be repealed on January 1, 2028)

Sec. 35. Qualifications for assistant behavior analyst license.

(a) A person qualifies to be licensed as an assistant behavior analyst if that person:

(1) has applied in writing or electronically on forms prescribed by the Department;

(2) is a graduate of a bachelor's level program in the field of behavior analysis or a related field with an equivalent course of study in behavior analysis approved by the Department from a regionally accredited university ~~approved by the Department~~;

(3) has met the supervised work experience;

(4) has qualified for and passed the examination for the practice of behavior analysis as a licensed assistant behavior analyst as authorized by the Department; and

(5) has paid the required fees.

(b) The Department may issue a license to a certified assistant behavior analyst seeking licensure as a licensed assistant behavior analyst who (i) does not have the supervised experience as described in paragraph (3) of subsection (a), (ii) applies for licensure before July 1, 2028, and (iii) has completed all of the following:

(1) has applied in writing or electronically on forms prescribed by the Department;

(2) is a graduate of a bachelor's ~~bachelors~~ level program in the field of behavior analysis;

(3) submits evidence of certification by an appropriate national certifying body as determined by rule of the Department;

(4) has passed the examination for the practice of behavior analysis as authorized by the Department; and

(5) has paid the required fees.

(c) An applicant has 3 years after the date of application to complete the application process. If the process has not been completed in 3 years, the application shall be denied, the fee shall be forfeited, and the applicant must reapply and meet the requirements in effect at the time of reapplication.

(d) Each applicant for licensure as an assistant behavior analyst shall have his or her fingerprints submitted to the Illinois State Police in an electronic format that complies with the form and manner for requesting and furnishing criminal history record information as prescribed by the Illinois State Police. These fingerprints shall be transmitted through a live scan fingerprint vendor licensed by the Department. These fingerprints shall be checked against the Illinois State Police and Federal Bureau of Investigation criminal history record databases now and hereafter filed, including, but not limited to, civil, criminal, and latent fingerprint databases. The Illinois State Police shall charge a fee for conducting the criminal history records check, which shall be deposited in the State Police Services Fund and shall not exceed the actual cost of the records check. The Illinois State Police shall furnish, pursuant to positive identification, records of Illinois convictions as prescribed under the Illinois Uniform Conviction Information Act and shall forward the national criminal history record information to the Department.

(Source: P.A. 102-953, eff. 5-27-22; revised 8-19-22.)

(225 ILCS 6/150)

(Section scheduled to be repealed on January 1, 2028)

Sec. 150. License restrictions and limitations. Notwithstanding the exclusion in paragraph (2) of subsection (c) of Section 20 that permits an individual to implement a behavior analytic treatment plan under the extended authority, direction, and supervision of a licensed behavior analyst or licensed assistant behavior analyst, no ~~No~~ business organization shall provide, attempt to provide, or offer to provide behavior analysis services unless every member, partner, shareholder, director, officer, holder of any other ownership interest, agent, and employee who renders applied behavior analysis services holds a currently valid license issued under this Act. No business shall be created that (i) has a stated purpose that includes behavior analysis, or (ii) practices or holds itself out as available to practice behavior analysis therapy, unless it is organized under the Professional Service Corporation Act or Professional Limited Liability Company Act. Nothing in this Act shall preclude individuals licensed under this Act from practicing directly or indirectly for a physician licensed to practice medicine in all its branches under the Medical Practice Act of 1987 or for any legal entity as provided under subsection (c) of Section 22.2 of the Medical Practice Act of 1987.

(Source: P.A. 102-953, eff. 5-27-22.)

Section 20. The Podiatric Medical Practice Act of 1987 is amended by adding Section 18.1 as follows:

(225 ILCS 100/18.1 new)

Sec. 18.1. Fee waivers. Notwithstanding any provision of law to the contrary, during State Fiscal Year 2023, the Department shall allow individuals a one-time waiver of fees imposed under Section 18 of this Act. No individual may benefit from such a waiver more than once. If an individual has already paid a fee required under Section 18 for Fiscal Year 2023, then the Department shall apply the money paid for that fee as a credit to the next required fee.

Section 25. The Nurse Agency Licensing Act is amended by changing Sections 3, 14, and 14.3 as follows:

(225 ILCS 510/3) (from Ch. 111, par. 953)

Sec. 3. Definitions. As used in this Act:

"Certified nurse aide" means an individual certified as defined in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, or Section 3-206 of the MC/DD Act, as now or hereafter amended.

"Covenant not to compete" means an agreement between a nurse agency and an employee that restricts the employee from performing:

(1) any work for another employer for a specified period of time;

(2) any work in a specified geographic area; or

(3) any work for another employer that is similar to the work the employee performs for the employer that is a party to the agreement.

"Department" means the Department of Labor.

"Director" means the Director of Labor.

"Employee" means a nurse or a certified nurse aide.

"Health care facility" is defined as in Section 3 of the Illinois Health Facilities Planning Act, as now or hereafter amended. "Health care facility" also includes any facility licensed, certified, or approved by any State agency and subject to regulation under the Assisted Living and Shared Housing Act or the Illinois Public Aid Code.

"Licensee" means any nurse ~~nursing~~ agency which is properly licensed under this Act.

"Long-term basis" means an initial employment, assignment, or referral term of more than 24 continuous months.

"Nurse" means a registered nurse, a licensed practical nurse, an advanced practice registered nurse, or any individual licensed under the Nurse Practice Act.

"Nurse agency" means any individual, firm, corporation, partnership, or other legal entity that employs, assigns, or refers nurses or certified nurse aides to a health care facility for a fee. The term "nurse agency" includes nurses

registries. The term "nurse agency" does not include services provided by home health agencies licensed and operated under the Home Health, Home Services, and Home Nursing Agency Licensing Act or a licensed or certified individual who provides his or her own services as a regular employee of a health care facility, nor does it apply to a health care facility's organizing nonsalaried employees to provide services only in that facility.

"Temporary basis" means an initial employment, assignment, or referral term of 24 continuous months or less exclusive of any extension.

(Source: P.A. 102-946, eff. 7-1-22.)

(225 ILCS 510/14) (from Ch. 111, par. 964)

Sec. 14. Minimum Standards.

(a) The Department, by rule, shall establish minimum standards for the operation of nurse agencies. Those standards shall include, but are not limited to:

(1) the maintenance of written policies and procedures;

(2) the maintenance and submission to the Department of copies of all contracts between the nurse agency and health care facility to which it assigns or refers nurses or certified nurse aides and copies of all invoices to health care facilities personnel. Executed contracts must be sent to the Department within 5 business days of their

effective date; ~~and~~

(3) the development of personnel policies for nurses or certified nurse aides employed, assigned, or referred to health care facilities, including a personal interview, a reference check, an annual evaluation of each employee (which may be based in part upon information provided by health care facilities utilizing nurse agency personnel)~~,~~ and periodic health examinations. Executed contracts must be sent to the Department within 5 business days of their effective date and are not subject to disclosure under the Freedom of Information Act; and~~.~~

(4) a requirement that no ~~No~~ less than 100% of the nurse or certified nurse aide hourly rate shall be paid to the nurse or certified nurse aide employee.

The requirements to maintain and submit contracts and invoices to the Department under subparagraphs (2) and (3) of this subsection do not apply to (i) contracts on a long-term basis for the employment, assignment, or referral of nurses by a nurse agency to a health care facility, (ii) contracts on a long-term basis for the employment, assignment, or referral of certified nurse aides by a nurse agency to a health care facility, or (iii) invoices for contracts described in item (i) or (ii). However, a nurse agency that is exempt from the requirements of subparagraphs (2) and (3) of this subsection must submit the information described in items (i), (ii), and (iii) upon request by the Department pursuant to Section 14.1.

(b) Each nurse agency shall have a nurse serving as a manager or supervisor of all nurses and certified nurses aides.

(c) Each nurse agency shall ensure that its employees meet the minimum licensing, training, continuing education, and orientation standards for which those employees are licensed or certified.

(d) A nurse agency shall not employ, assign, or refer for use in an Illinois health care facility a nurse or certified nurse aide unless certified or licensed under applicable provisions of State and federal law or regulations. Each certified nurse aide shall comply with all pertinent regulations of the Illinois Department of Public Health relating to the health and other qualifications of personnel employed in health care facilities.

(e) The Department may adopt rules to monitor the usage of nurse agency services to determine their impact.

(f) Nurse agencies are prohibited from recruiting potential employees on the premises of a health care facility or requiring, as a condition of employment, assignment, or referral, that their employees recruit new employees for the nurse agency from among the permanent employees of the health care facility to which the nurse agency employees have been employed, assigned, or referred, and the health care facility to which such employees are employed, assigned, or referred is prohibited from requiring, as a condition of employment, that

their employees recruit new employees from these nurse agency employees. Violation of this provision is a business offense.

(g) Nurse agencies are prohibited from entering into covenants not to compete with nurses and certified nurse aides if the nurse is employed, assigned, or referred by a nurse agency to a health care facility on a temporary basis or the certified nurse aide is employed, assigned, or referred by a nurse agency to a health care facility on a temporary basis. A covenant not to compete entered into on or after July 1, 2022 (the effective date of Public Act 102-946) ~~this amendatory Act of the 102nd General Assembly~~ between a nurse agency and a nurse or a certified nurse aide is illegal and void if (i) the nurse is employed, assigned, or referred by a nurse agency to a health care facility on a temporary basis or (ii) the certified nurse aide is employed, assigned, or referred by a nurse agency to a health care facility on a temporary basis ~~is illegal and void~~. The nurse ~~nursing~~ agency shall not, in any contract on a temporary basis with any nurse, certified nurse aide, ~~employee~~ or health care facility, require the payment of liquidated damages, conversion fees, employment fees, buy-out fees, placement fees, or other compensation if the nurse or certified nurse aide ~~employee~~ is hired as a permanent employee of the ~~a~~ health care facility. However, a nurse agency may, in a contract on a long-term basis with any nurse, certified nurse aide, or health care facility, require the payment of liquidated damages, conversion fees, employment fees, buy-out

fees, placement fees, or other compensation if the nurse or certified nurse aide is hired before the expiration of a covenant not to compete as a permanent employee of the health care facility.

(h) A nurse agency shall submit a report quarterly to the Department for each health care entity with whom the agency contracts that includes all of the following by provider type and county in which the work was performed:

(1) A list of the average amount charged to the health care facility for each individual employee category.

(2) A list of the average amount paid by the agency to employees in each individual employee category.

(3) A list of the average amount of labor-related costs paid by the agency for each employee category, including payroll taxes, workers' compensation insurance, professional liability coverage, credentialing and testing, and other employee related costs.

The Department shall publish by county in which the work was performed the average amount charged to the health care facilities by nurse agencies for each individual worker category and the average amount paid by the agency to each individual worker category. This subsection does not apply to a nurse or certified nurse aide if the nurse or certified nurse aide is employed, assigned, or referred by a nurse agency to a health care facility on a long-term basis. However, a nurse agency that is exempt from the requirements of this subsection

must submit the information required by this subsection upon request by the Department pursuant to Section 14.1.

(i) The Department shall publish on its website the reports yearly by county.

(j) The Department of Labor shall compel production of the maintained records, as required under this Section, by the nurse agencies.

(Source: P.A. 102-946, eff. 7-1-22.)

(225 ILCS 510/14.3)

Sec. 14.3. Contracts between nurse agencies and health care facilities.

(a) A contract entered into on or after the effective date of this amendatory Act of the 102nd General Assembly between the nurse agency and health care facility must contain the following provisions:

(1) A full disclosure of charges and compensation. The disclosure shall include a schedule of all hourly bill rates per category of employee, a full description of administrative charges, and a schedule of rates of all compensation per category of employee, including, but not limited to, hourly regular pay rate, shift differential, weekend differential, hazard pay, charge nurse add-on, overtime, holiday pay, and travel or mileage pay.

(2) A commitment that nurses or certified nurse aides employed, assigned, or referred to a health care facility

by the nurse agency perform any and all duties called for within the full scope of practice for which the nurse or certified nurse aide is licensed or certified.

(3) No less than 100% of the nurse or certified nurse aide hourly rate shall be paid to the nurse or certified nurse aide employee.

(b) A party's failure to comply with the requirements of subsection (a) shall be a defense to the enforcement of a contract between a nurse agency and a health care facility. Any health care facility or nurse agency aggrieved by a violation of subsection (a) shall have a right of action in a State court against the offending party. A prevailing party may recover for each violation:

(1) liquidated damages of $1,500 or actual damages, whichever is greater;

(2) reasonable attorney's fees and costs, including expert witness fees and other litigation expenses; and

(3) other relief, including an injunction, as the court may deem appropriate.

(c) This Section does not apply to contracts on a long-term basis between a nurse agency and a health care facility providing for the employment, assignment, or referral of nurses or certified nurse aides to the health care facility. However, a nurse agency that is exempt from the requirements of this Section must submit the information required by this Section upon request by the Department

pursuant to Section 14.1.

(Source: P.A. 102-946, eff. 7-1-22.)

Section 30. The Illinois Public Aid Code is amended by changing Sections 5-5.02, 5-5.2, 5-5.7b, and 5B-2 as follows:

(305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

Sec. 5-5.02. Hospital reimbursements.

(a) Reimbursement to hospitals; July 1, 1992 through September 30, 1992. Notwithstanding any other provisions of this Code or the Illinois Department's Rules promulgated under the Illinois Administrative Procedure Act, reimbursement to hospitals for services provided during the period July 1, 1992 through September 30, 1992, shall be as follows:

(1) For inpatient hospital services rendered, or if applicable, for inpatient hospital discharges occurring, on or after July 1, 1992 and on or before September 30, 1992, the Illinois Department shall reimburse hospitals for inpatient services under the reimbursement methodologies in effect for each hospital, and at the inpatient payment rate calculated for each hospital, as of June 30, 1992. For purposes of this paragraph, "reimbursement methodologies" means all reimbursement methodologies that pertain to the provision of inpatient hospital services, including, but not limited to, any adjustments for disproportionate share, targeted access,

critical care access and uncompensated care, as defined by the Illinois Department on June 30, 1992.

(2) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for targeted access and critical care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period July 1, 1992 through September 30, 1992, shall be 25% of the annual adjustment payments calculated for each eligible hospital, as of June 30, 1992. The Illinois Department shall determine by rule the adjustment payments for targeted access and critical care beginning October 1, 1992.

(3) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for uncompensated care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care adjustment payments calculated for each eligible hospital for the uncompensated care rate year, as defined by the Illinois Department, ending on July 31, 1992. The Illinois Department shall determine by rule the adjustment payments for uncompensated care beginning October 1, 1992.

(b) Inpatient payments. For inpatient services provided on

or after October 1, 1993, in addition to rates paid for hospital inpatient services pursuant to the Illinois Health Finance Reform Act, as now or hereafter amended, or the Illinois Department's prospective reimbursement methodology, or any other methodology used by the Illinois Department for inpatient services, the Illinois Department shall make adjustment payments, in an amount calculated pursuant to the methodology described in paragraph (c) of this Section, to hospitals that the Illinois Department determines satisfy any one of the following requirements:

(1) Hospitals that are described in Section 1923 of the federal Social Security Act, as now or hereafter amended, except that for rate year 2015 and after a hospital described in Section 1923(b)(1)(B) of the federal Social Security Act and qualified for the payments described in subsection (c) of this Section for rate year 2014 provided the hospital continues to meet the description in Section 1923(b)(1)(B) in the current determination year; or

(2) Illinois hospitals that have a Medicaid inpatient utilization rate which is at least one-half a standard deviation above the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department; or

(3) Illinois hospitals that on July 1, 1991 had a Medicaid inpatient utilization rate, as defined in

paragraph (h) of this Section, that was at least the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department and which were located in a planning area with one-third or fewer excess beds as determined by the Health Facilities and Services Review Board, and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area; or

(4) Illinois hospitals that:

(A) have a Medicaid inpatient utilization rate that is at least equal to the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department; and

(B) also have a Medicaid obstetrical inpatient utilization rate that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department for obstetrical services; or

(5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children if either (i) the facility devoted exclusively to caring for children is separately licensed as a

hospital by a municipality prior to February 28, 2013; (ii) the hospital has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization rate greater than 55% for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days as defined by the Department in rulemaking; (iii) the hospital has been designated as a Perinatal Level III center by the State as of December 1, 2017, is a Pediatric Critical Care Center designated by the State as of December 1, 2017 and has a 2017 Medicaid inpatient utilization rate equal to or greater than 45%; or (iv) the hospital has been designated as a Perinatal Level II center by the State as of December 1, 2017, has a 2017 Medicaid Inpatient Utilization Rate greater than 70%, and has at least 10 pediatric beds as listed on the IDPH 2015 calendar year hospital profile; or

(6) A hospital that reopens a previously closed hospital facility within 4 calendar years of the hospital facility's closure, if the previously closed hospital facility qualified for payments under paragraph (c) at the time of closure, until utilization data for the new facility is available for the Medicaid inpatient utilization rate calculation. For purposes of this clause, a "closed hospital facility" shall include hospitals that have been terminated from participation in the medical assistance program in accordance with Section 12-4.25 of

this Code.

(c) Inpatient adjustment payments. The adjustment payments required by paragraph (b) shall be calculated based upon the hospital's Medicaid inpatient utilization rate as follows:

(1) hospitals with a Medicaid inpatient utilization rate below the mean shall receive a per day adjustment payment equal to $25;

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

(3) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate;

(4) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard

deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate; and

(5) hospitals qualifying under clause (6) of paragraph (b) shall have the rate assigned to the previously closed hospital facility at the date of closure, until utilization data for the new facility is available for the Medicaid inpatient utilization rate calculation.

(c-1) Effective October 1, 2023, for rate year 2024 and thereafter, the Medicaid Inpatient utilization rate, as defined in paragraph (1) of subsection (h) and used in the determination of eligibility for payments under paragraph (c), shall be modified to exclude from both the numerator and denominator all days of care provided to military recruits or trainees for the United States Navy and covered by TriCare or its successor.

(d) Supplemental adjustment payments. In addition to the adjustment payments described in paragraph (c), hospitals as defined in clauses (1) through (6) of paragraph (b), excluding county hospitals (as defined in subsection (c) of Section 15-1 of this Code) and a hospital organized under the University of Illinois Hospital Act, shall be paid supplemental inpatient adjustment payments of $60 per day. For purposes of Title XIX

of the federal Social Security Act, these supplemental adjustment payments shall not be classified as adjustment payments to disproportionate share hospitals.

(e) The inpatient adjustment payments described in paragraphs (c) and (d) shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12-month ~~12 month~~ period for which data are available, or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate. The sum of the inpatient adjustment payments under paragraphs (c) and (d) to a hospital, other than a county hospital (as defined in subsection (c) of Section 15-1 of this Code) or a hospital organized under the University of Illinois Hospital Act, however, shall not exceed $275 per day; that limit shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12-month period for which data are available or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate.

(f) Children's hospital inpatient adjustment payments. For children's hospitals, as defined in clause (5) of paragraph (b), the adjustment payments required pursuant to paragraphs (c) and (d) shall be multiplied by 2.0.

(g) County hospital inpatient adjustment payments. For county hospitals, as defined in subsection (c) of Section 15-1 of this Code, there shall be an adjustment payment as determined by rules issued by the Illinois Department.

(h) For the purposes of this Section the following terms shall be defined as follows:

(1) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, and the denominator of which is the total number of the hospital's inpatient days in that same period.

(2) "Mean Medicaid inpatient utilization rate" means the total number of Medicaid inpatient days provided by all Illinois Medicaid-participating hospitals divided by the total number of inpatient days provided by those same hospitals.

(3) "Medicaid obstetrical inpatient utilization rate" means the ratio of Medicaid obstetrical inpatient days to total Medicaid inpatient days for all Illinois hospitals receiving Medicaid payments from the Illinois Department.

(i) Inpatient adjustment payment limit. In order to meet the limits of Public Law 102-234 and Public Law 103-66, the Illinois Department shall by rule adjust disproportionate share adjustment payments.

(j) University of Illinois Hospital inpatient adjustment payments. For hospitals organized under the University of Illinois Hospital Act, there shall be an adjustment payment as determined by rules adopted by the Illinois Department.

(k) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(l) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(m) The Department shall establish a cost-based reimbursement methodology for determining payments to hospitals for approved graduate medical education (GME) programs for dates of service on and after July 1, 2018.

(1) As used in this subsection, "hospitals" means the University of Illinois Hospital as defined in the University of Illinois Hospital Act and a county hospital in a county of over 3,000,000 inhabitants.

(2) An amendment to the Illinois Title XIX State Plan defining GME shall maximize reimbursement, shall not be limited to the education programs or special patient care payments allowed under Medicare, and shall include:

(A) inpatient days;

(B) outpatient days;

(C) direct costs;

(D) indirect costs;

(E) managed care days;

(F) all stages of medical training and education including students, interns, residents, and fellows with no caps on the number of persons who may qualify; and

(G) patient care payments related to the complexities of treating Medicaid enrollees including clinical and social determinants of health.

(3) The Department shall make all GME payments directly to hospitals including such costs in support of clients enrolled in Medicaid managed care entities.

(4) The Department shall promptly take all actions necessary for reimbursement to be effective for dates of service on and after July 1, 2018 including publishing all appropriate public notices, amendments to the Illinois Title XIX State Plan, and adoption of administrative rules if necessary.

(5) As used in this subsection, "managed care days" means costs associated with services rendered to enrollees of Medicaid managed care entities. "Medicaid managed care entities" means any entity which contracts with the Department to provide services paid for on a capitated basis. "Medicaid managed care entities" includes a managed care organization and a managed care community network.

(6) All payments under this Section are contingent upon federal approval of changes to the Illinois Title XIX State Plan, if that approval is required.

(7) The Department may adopt rules necessary to implement Public Act 100-581 through the use of emergency rulemaking in accordance with subsection (aa) of Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement Public Act 100-581 is deemed an emergency and necessary for the public interest, safety, and welfare.

(Source: P.A. 101-81, eff. 7-12-19; 102-682, eff. 12-10-21; 102-886, eff. 5-17-22.)

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

Sec. 5-5.2. Payment.

(a) All nursing facilities that are grouped pursuant to Section 5-5.1 of this Act shall receive the same rate of payment for similar services.

(b) It shall be a matter of State policy that the Illinois Department shall utilize a uniform billing cycle throughout the State for the long-term care providers.

(c) (Blank).

(c-1) Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for

bills payable for nursing services rendered on or after a new reimbursement system based on the Patient Driven Payment Model (PDPM) has been fully operationalized, which shall take effect for services provided on or after the implementation of the PDPM reimbursement system begins. For the purposes of this amendatory Act of the 102nd General Assembly, the implementation date of the PDPM reimbursement system and all related provisions shall be July 1, 2022 if the following conditions are met: (i) the Centers for Medicare and Medicaid Services has approved corresponding changes in the reimbursement system and bed assessment; and (ii) the Department has filed rules to implement these changes no later than June 1, 2022. Failure of the Department to file rules to implement the changes provided in this amendatory Act of the 102nd General Assembly no later than June 1, 2022 shall result in the implementation date being delayed to October 1, 2022.

(d) The new nursing services reimbursement methodology utilizing the Patient Driven Payment Model, which shall be referred to as the PDPM reimbursement system, taking effect July 1, 2022, upon federal approval by the Centers for Medicare and Medicaid Services, shall be based on the following:

(1) The methodology shall be resident-centered, facility-specific, cost-based, and based on guidance from the Centers for Medicare and Medicaid Services.

(2) Costs shall be annually rebased and case mix index

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) Regional wage adjustors based on the Health Service Areas (HSA) groupings and adjusters in effect on April 30, 2012 shall be included, except no adjuster shall be lower than 1.06.

(4) PDPM nursing case mix indices in effect on March 1, 2022 shall be assigned to each resident class at no less than 0.7858 of the Centers for Medicare and Medicaid Services PDPM unadjusted case mix values, in effect on March 1, 2022~~, 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).

(6) The Department shall establish a variable per diem staffing add-on in accordance with the most recent available federal staffing report, currently the Payroll Based Journal, for the same period of time, and if applicable adjusted for acuity using the same quarter's MDS. The Department shall rely on Payroll Based Journals provided to the Department of Public Health to make a

determination of non-submission. If the Department is notified by a facility of missing or inaccurate Payroll Based Journal data or an incorrect calculation of staffing, the Department must make a correction as soon as the error is verified for the applicable quarter.

Facilities with at least 70% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $9, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem of $14.88. Facilities with at least 80% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $14.88, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $23.80. Facilities with at least 92% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $23.80, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $29.75. Facilities with at least 100% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $29.75, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $35.70. Facilities with at least 110% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $35.70, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $38.68. Facilities with at

least 125% or higher of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $38.68. Beginning April 1, 2023, no nursing facility's variable staffing per diem add-on shall be reduced by more than 5% in 2 consecutive quarters. For the 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% of the staffing indicated by the STRIVE study. 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.

(7) For dates of services beginning July 1, 2022, the PDPM nursing component per diem for each nursing facility shall be the product of the facility's (i) statewide PDPM nursing base per diem rate, $92.25, adjusted for the facility average PDPM case mix index calculated quarterly and (ii) the regional wage adjuster, and then add the Medicaid access adjustment as defined in (e-3) of this Section. Transition rates for services provided between July 1, 2022 and October 1, 2023 shall be the greater of the PDPM nursing component per diem or:

(A) for the quarter beginning July 1, 2022, the RUG-IV nursing component per diem;

(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 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 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 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; or

(F) for the quarter beginning October 1, 2023 and each subsequent quarter, the transition rate shall end and a nursing facility shall be paid 100% of the PDPM nursing component per diem.

(d-1) Calculation of base year Statewide RUG-IV nursing base per diem rate.

(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 effect on July 1, 2012 shall be multiplied by

subsection (A).

(C) Thirteen million is added to the product of subparagraph (A) and subparagraph (B) to adjust for the exclusion of nursing homes defined in paragraph (5).

(2) For each nursing home with Medicaid residents as indicated by the MDS data defined in paragraph (4), weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each home this calculation is the product of:

(A) Base year resident days as calculated in subparagraph (A) of paragraph (1).

(B) The nursing home's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.

(C) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in paragraph (4) multiplied by the associated case weight for the RUG-IV 48 grouper model using standard RUG-IV procedures for index maximization.

(D) The sum of the products calculated for each nursing home in subparagraphs (A) through (C) above shall be the base year case mix, rate adjusted weighted days.

(3) The Statewide RUG-IV nursing base per diem rate:

(A) on January 1, 2014 shall be the quotient of the

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

(B) on and after July 1, 2014 and until July 1, 2022, shall be the amount calculated under subparagraph (A) of this paragraph (3) plus $1.76; and

(C) beginning July 1, 2022 and thereafter, $7 shall be added to the amount calculated under subparagraph (B) of this paragraph (3) of this Section.

(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 until September 30, 2023, or for each resident who scores a "1" or "2" in PDPM groups PA1, PA2, BAB1, or BAB2 beginning July 1, 2022 and thereafter.

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014 and ending September 30, 2023, the RUG-IV nursing component per diem for a nursing home shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index, and the regional wage adjustor.

(e-3) A Medicaid Access Adjustment of $4 adjusted for the facility average PDPM case mix index calculated quarterly shall be added to the statewide PDPM nursing per diem for all facilities with annual Medicaid bed days of at least 70% of all occupied bed days adjusted quarterly. For each new calendar year and for the 6-month period beginning July 1, 2022, the percentage of a facility's occupied bed days comprised of Medicaid bed days shall be determined by the Department quarterly. Beginning on the effective date of this amendatory Act of the 102nd General Assembly, the Medicaid Access Adjustment of $4 shall be increased by $0.75 and the increased reimbursement rate shall be applied to services rendered on and after July 1, 2022. The Department shall recalculate each affected facility's reimbursement rate retroactive to July 1, 2022 and remit all additional money owed to each facility as a result of the retroactive recalculation. This subsection shall

be inoperative on and after January 1, 2028.

(f) (Blank).

(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) (Blank);

(2) (Blank);

(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) Notwithstanding any other provision of law, subject to

federal approval, effective July 1, 2019, sufficient funds shall be allocated for changes to rates for facilities licensed under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities for dates of services on and after July 1, 2019: (i) to establish, through June 30, 2022 a per diem add-on to the direct care per diem rate not to exceed $70,000,000 annually in the aggregate taking into account federal matching funds for the purpose of addressing the facility's unique staffing needs, adjusted quarterly and distributed by a weighted formula based on Medicaid bed days on the last day of the second quarter preceding the quarter for which the rate is being adjusted. Beginning July 1, 2022, the annual $70,000,000 described in the preceding sentence shall be dedicated to the variable per diem add-on for staffing under paragraph (6) of subsection (d); and (ii) in an amount not to exceed $170,000,000 annually in the aggregate taking into account federal matching funds to permit the support component of the nursing facility rate to be updated as follows:

(1) 80%, or $136,000,000, of the funds shall be used to update each facility's rate in effect on June 30, 2019 using the most recent cost reports on file, which have had a limited review conducted by the Department of Healthcare and Family Services and will not hold up enacting the rate increase, with the Department of Healthcare and Family Services.

(2) After completing the calculation in paragraph (1), any facility whose rate is less than the rate in effect on June 30, 2019 shall have its rate restored to the rate in effect on June 30, 2019 from the 20% of the funds set aside.

(3) The remainder of the 20%, or $34,000,000, shall be used to increase each facility's rate by an equal percentage.

(k) During the first quarter of State Fiscal Year 2020, the Department of Healthcare of Family Services must convene a technical advisory group consisting of members of all trade associations representing Illinois skilled nursing providers to discuss changes necessary with federal implementation of Medicare's Patient-Driven Payment Model. Implementation of Medicare's Patient-Driven Payment Model shall, by September 1, 2020, end the collection of the MDS data that is necessary to maintain the current RUG-IV Medicaid payment methodology. The technical advisory group must consider a revised reimbursement methodology that takes into account transparency, accountability, actual staffing as reported under the federally required Payroll Based Journal system, changes to the minimum wage, adequacy in coverage of the cost of care, and a quality component that rewards quality improvements.

(l) The Department shall establish per diem add-on payments to improve the quality of care delivered by facilities, including:

(1) Incentive payments determined by facility performance on specified quality measures in an initial amount of $70,000,000. Nothing in this subsection shall be construed to limit the quality of care payments in the aggregate statewide to $70,000,000, and, if quality of care has improved across nursing facilities, the Department shall adjust those add-on payments accordingly. The quality payment methodology described in this subsection must be used for at least State Fiscal Year 2023. Beginning with the quarter starting July 1, 2023, the Department may add, remove, or change quality metrics and make associated changes to the quality payment methodology as outlined in subparagraph (E). 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.

(A) Each quality pool must be distributed by assigning a quality weighted score for each nursing home which is calculated by multiplying the nursing home's quality base period Medicaid days by the nursing home's star rating weight in that period.

(B) Star rating weights are assigned based on the nursing home's star rating for the LTS quality star rating. As used in this subparagraph, "LTS quality star rating" means the long-term stay quality rating for each nursing facility, as assigned by the Centers

for Medicare and Medicaid Services under the Five-Star Quality Rating System. The rating is a number ranging from 0 (lowest) to 5 (highest).

(i) Zero-star or one-star rating has a weight of 0.

(ii) Two-star rating has a weight of 0.75.

(iii) Three-star rating has a weight of 1.5.

(iv) Four-star rating has a weight of 2.5.

(v) Five-star rating has a weight of 3.5.

(C) Each nursing home's quality weight score is divided by the sum of all quality weight scores for qualifying nursing homes to determine the proportion of the quality pool to be paid to the nursing home.

(D) The quality pool is no less than $70,000,000 annually or $17,500,000 per quarter. The Department shall publish on its website the estimated payments and the associated weights for each facility 45 days prior to when the initial payments for the quarter are to be paid. The Department shall assign each facility the most recent and applicable quarter's STAR value unless the facility notifies the Department within 15 days of an issue and the facility provides reasonable evidence demonstrating its timely compliance with federal data submission requirements for the quarter of record. If such evidence cannot be provided to the Department, the STAR rating assigned to the facility

shall be reduced by one from the prior quarter.

(E) The Department shall review quality metrics used for payment of the quality pool and make recommendations for any associated changes to the methodology for distributing quality pool payments in consultation with associations representing long-term care providers, consumer advocates, organizations representing workers of long-term care facilities, and payors. The Department may establish, by rule, changes to the methodology for distributing quality pool payments.

(F) The Department shall disburse quality pool payments from the Long-Term Care Provider Fund on a monthly basis in amounts proportional to the total quality pool payment determined for the quarter.

(G) The Department shall publish any changes in the methodology for distributing quality pool payments prior to the beginning of the measurement period or quality base period for any metric added to the distribution's methodology.

(2) Payments based on CNA tenure, promotion, and CNA training for the purpose of increasing CNA compensation. It is the intent of this subsection that payments made in accordance with this paragraph be directly incorporated into increased compensation for CNAs. As used in this paragraph, "CNA" means a certified nursing assistant as

that term is described in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, and Section 3-206 of the MC/DD Act. The Department shall establish, by rule, payments to nursing facilities equal to Medicaid's share of the tenure wage increments specified in this paragraph for all reported CNA employee hours compensated according to a posted schedule consisting of increments at least as large as those specified in this paragraph. The increments are as follows: an additional $1.50 per hour for CNAs with at least one and less than 2 years' experience plus another $1 per hour for each additional year of experience up to a maximum of $6.50 for CNAs with at least 6 years of experience. For purposes of this paragraph, Medicaid's share shall be the ratio determined by paid Medicaid bed days divided by total bed days for the applicable time period used in the calculation. In addition, and additive to any tenure increments paid as specified in this paragraph, the Department shall establish, by rule, payments supporting Medicaid's share of the promotion-based wage increments for CNA employee hours compensated for that promotion with at least a $1.50 hourly increase. Medicaid's share shall be established as it is for the tenure increments described in this paragraph. Qualifying promotions shall be defined by the Department in rules for an expected 10-15% subset of CNAs

assigned intermediate, specialized, or added roles such as CNA trainers, CNA scheduling "captains", and CNA specialists for resident conditions like dementia or memory care or behavioral health.

(m) The Department shall work with nursing facility industry representatives to design policies and procedures to permit facilities to address the integrity of data from federal reporting sites used by the Department in setting facility rates.

(Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19; 102-77, eff. 7-9-21; 102-558, eff. 8-20-21; 102-1035, eff. 5-31-22.)

(305 ILCS 5/5-5.7b)

Sec. 5-5.7b. Pandemic related stability payments to ambulance service providers in response to COVID-19.

(a) Definitions. As used in this Section:

"Ambulance Services Industry" means the industry that is comprised of "Qualifying Ground Ambulance Service Providers", as defined in this Section.

"Qualifying Ground Ambulance Service Provider" means a "vehicle service provider," as that term is defined in Section 3.85 of the Emergency Medical Services (EMS) Systems Act, which operates licensed ambulances for the purpose of providing emergency, non-emergency ambulance services, or both emergency and non-emergency ambulance services. The term

"Qualifying Ground Ambulance Service Provider" is limited to ambulance and EMS agencies that are privately held and nonprofit organizations headquartered within the State and licensed by the Department of Public Health as of March 12, 2020.

"Eligible worker" means a staff member of a Qualifying Ground Ambulance Service Provider engaged in "essential work", as defined by Section 9901 of the ARPA and related federal guidance, and (1) whose total pay is below 150% of the average annual wage for all occupations in the worker's county of residence, as defined by the BLS Occupational Employment and Wage Statistics or (2) is not exempt from the federal Fair Labor Standards Act overtime provisions.

(b) Purpose. The Department may receive federal funds under the authority of legislation passed in response to the Coronavirus epidemic, including, but not limited to, the American Rescue Plan Act of 2021, P.L. 117-2 (the "ARPA"). Upon receipt or availability of such State or federal funds, and subject to appropriations for their use, the Department shall establish and administer programs for purposes allowable under Section 9901 of the ARPA to provide financial assistance to Qualifying Ground Ambulance Service Providers for premium pay for eligible workers, to provide reimbursement for eligible expenditures, and to provide support following the negative economic impact of the COVID-19 public health emergency on the Ambulance Services Industry. Financial

assistance may include, but is not limited to, grants, expense reimbursements, or subsidies.

(b-1) By December 31, 2022, the Department shall obtain appropriate documentation from Qualifying Ground Ambulance Service Providers to ascertain an accurate count of the number of licensed vehicles available to serve enrollees in the State's Medical Assistance Programs, which shall be known as the "total eligible vehicles". By February 28, 2023, Qualifying Ground Ambulance Service Providers shall be initially notified of their eligible award, which shall be the product of (i) the total amount of funds allocated under this Section and (ii) a quotient, the numerator of which is the number of licensed ground ambulance vehicles of an individual Qualifying Ground Ambulance Service Provider and the denominator of which is the total eligible vehicles. After March 31, 2024, any unobligated funds shall be reallocated pro rata to the remaining Qualifying Ground Ambulance Service Providers that are able to prove up eligible expenses in excess of their initial award amount until all such appropriated funds are exhausted.

Providers shall indicate to the Department what portion of their award they wish to allocate under the purposes outlined under paragraphs (d), (e), or (f), if applicable, of this Section.

(c) Non-Emergency Service Certification. To be eligible for funding under this Section, a Qualifying Ground Ambulance

Service Provider that provides non-emergency services to institutional residents must certify whether or not it is able to ~~that it will~~ provide non-emergency ambulance services to individuals enrolled in the State's Medical Assistance Program and residing in non-institutional settings for at least one year following the receipt of funding pursuant to this amendatory Act of the 102nd General Assembly. Certification indicating that a provider has such an ability does not mean that a provider is required to accept any or all requested transports. ~~The provider shall maintain the certification in its records. The provider shall also maintain documentation of all non-emergency ambulance services for the period covered by the certification. The provider shall produce the certification and supporting documentation upon demand by the Department or its representative. Failure to comply shall result in recovery of any payments made by the Department.~~

(d) Premium Pay Initiative. Subject to paragraph (c) of this Section, the Department shall establish a Premium Pay Initiative to distribute awards to each Qualifying Ground Ambulance Service Provider for the purpose of providing premium pay to eligible workers.

(1) Financial assistance pursuant to this paragraph (d) shall be scaled based on a process determined by the Department. The amount awarded to each Qualifying Ground Ambulance Service Provider shall be up to $13 per hour for each eligible worker employed.

(2) The financial assistance awarded shall only be expended for premium pay for eligible workers, which must be in addition to any wages or remuneration the eligible worker has already received and shall be subject to the other requirements and limitations set forth in the ARPA and related federal guidance.

(3) Upon receipt of funds, the Qualifying Ground Ambulance Service Provider shall distribute funds such that an eligible worker receives an amount up to $13 per hour but no more than $25,000 for the duration of the program. The Qualifying Ground Ambulance Service Provider shall provide a written certification to the Department acknowledging compliance with this paragraph (d).

(4) No portion of these funds shall be spent on volunteer staff.

(5) These funds shall not be used to make retroactive premium payments prior to the effective date of this amendatory Act of the 102nd General Assembly.

(6) The Department shall require each Qualifying Ground Ambulance Service Provider that receives funds under this paragraph (d) to submit appropriate documentation acknowledging compliance with State and federal law on an annual basis.

(e) COVID-19 Response Support Initiative. Subject to paragraph (c) of this Section and based on an application filed by a Qualifying Ground Ambulance Service Provider, the

Department shall establish the Ground Ambulance COVID-19 Response Support Initiative. The purpose of the award shall be to reimburse Qualifying Ground Ambulance Service Providers for eligible expenses under Section 9901 of the ARPA related to the public health impacts of the COVID-19 public health emergency, including, but not limited to: (i) costs incurred due to the COVID-19 public health emergency; (ii) costs related to vaccination programs, including vaccine incentives; (iii) costs related to COVID-19 testing; (iv) costs related to COVID-19 prevention and treatment equipment; (v) expenses for medical supplies; (vi) expenses for personal protective equipment; (vii) costs related to isolation and quarantine; (viii) costs for ventilation system installation and improvement; (ix) costs related to other emergency response equipment, such as ground ambulances, ventilators, cardiac monitoring equipment, defibrillation equipment, pacing equipment, ambulance stretchers, and radio equipment; and (x) other emergency medical response expenses. ~~costs related to COVID-19 testing for patients, COVID-19 prevention and treatment equipment, medical supplies, personal protective equipment, and other emergency medical response treatments.~~

(1) The award shall be for eligible obligated expenditures incurred no earlier than May 1, 2022 and no later than June 30, 2024 ~~2023~~. Expenditures under this paragraph must be incurred by June 30, 2025.

(2) Funds awarded under this paragraph (e) shall not

be expended for premium pay to eligible workers.

(3) The Department shall require each Qualifying Ground Ambulance Service Provider that receives funds under this paragraph (e) to submit appropriate documentation acknowledging compliance with State and federal law on an annual basis. For purchases of medical equipment or other capital expenditures, the Qualifying Ground Ambulance Service Provider shall include documentation that describes the harm or need to be addressed by the expenditures and how that capital expenditure is appropriate to address that identified harm or need.

(f) Ambulance Industry Recovery Program. If the Department designates the Ambulance Services Industry as an "impacted industry", as defined by the ARPA and related federal guidance, the Department shall establish the Ambulance Industry Recovery Grant Program, to provide aid to Qualifying Ground Ambulance Service Providers that experienced staffing losses due to the COVID-19 public health emergency.

(1) Funds awarded under this paragraph (f) shall not be expended for premium pay to eligible workers.

(2) Each Qualifying Ground Ambulance Service Provider that receives funds under this paragraph (f) shall comply with paragraph (c) of this Section.

(3) The Department shall require each Qualifying Ground Ambulance Service Provider that receives funds

under this paragraph (f) to submit appropriate documentation acknowledging compliance with State and federal law on an annual basis.

(Source: P.A. 102-699, eff. 4-19-22.)

(305 ILCS 5/5B-2) (from Ch. 23, par. 5B-2)

Sec. 5B-2. Assessment; no local authorization to tax.

(a) For the privilege of engaging in the occupation of long-term care provider, beginning July 1, 2011 through June 30, 2022, or upon federal approval by the Centers for Medicare and Medicaid Services of the long-term care provider assessment described in subsection (a-1), whichever is later, an assessment is imposed upon each long-term care provider in an amount equal to $6.07 times the number of occupied bed days due and payable each month. Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax, but shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider.

(a-1) For the privilege of engaging in the occupation of long-term care provider for each occupied non-Medicare bed day, beginning July 1, 2022, an assessment is imposed upon each long-term care provider in an amount varying with the number of paid Medicaid resident days per annum in the facility with the following schedule of occupied bed tax amounts. This assessment is due and payable each month. The

tax shall follow the schedule below and be rebased by the Department on an annual basis. The Department shall publish each facility's rebased tax rate according to the schedule in this Section 30 days prior to the beginning of the 6-month period beginning July 1, 2022 and thereafter 30 days prior to the beginning of each calendar year which shall incorporate the number of paid Medicaid days used to determine each facility's rebased tax rate.

(1) 0-5,000 paid Medicaid resident days per annum, $10.67.

(2) 5,001-15,000 paid Medicaid resident days per annum, $19.20.

(3) 15,001-35,000 paid Medicaid resident days per annum, $22.40.

(4) 35,001-55,000 paid Medicaid resident days per annum, $19.20.

(5) 55,001-65,000 paid Medicaid resident days per annum, $13.86.

(6) 65,001+ paid Medicaid resident days per annum, $10.67.

(7) Any non-profit nursing facilities without Medicaid-certified beds <u>or a nursing facility owned and operated by a county government</u>, $7 per occupied bed day.

Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax but shall not be billed or passed on to any resident of a nursing

home operated by the nursing home provider.

For each new calendar year and for the 6-month period beginning July 1, 2022, a facility's paid Medicaid resident days per annum shall be determined using the Department's Medicaid Management Information System to include Medicaid resident days for the year ending 9 months earlier.

(b) Nothing in this amendatory Act of 1992 shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon long-term care providers or the occupation of long-term care provider, or a tax or assessment measured by the income or earnings or occupied bed days of a long-term care provider.

(c) The assessment imposed by this Section shall not be due and payable, however, until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.2 of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and that the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(Source: P.A. 102-1035, eff. 5-31-22.)

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