

1 AN ACT concerning public aid.

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

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

6 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

7 Sec. 5-5.2. Payment.

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

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

14 (c) Notwithstanding any other provisions of this Code, the  
15 methodologies for reimbursement of nursing services as  
16 provided under this Article shall no longer be applicable for  
17 bills payable for nursing services rendered on or after a new  
18 reimbursement system based on the Resource Utilization Groups  
19 (RUGs) has been fully operationalized, which shall take effect  
20 for services provided on or after January 1, 2014.

21 (d) The new nursing services reimbursement methodology  
22 utilizing RUG-IV 48 grouper model, which shall be referred to  
23 as the RUGs reimbursement system, taking effect January 1,

1 2014, shall be based on the following:

2 (1) The methodology shall be resident-driven,  
3 facility-specific, and cost-based.

4 (2) Costs shall be annually rebased and case mix index  
5 quarterly updated. The nursing services methodology will  
6 be assigned to the Medicaid enrolled residents on record  
7 as of 30 days prior to the beginning of the rate period in  
8 the Department's Medicaid Management Information System  
9 (MMIS) as present on the last day of the second quarter  
10 preceding the rate period based upon the Assessment  
11 Reference Date of the Minimum Data Set (MDS).

12 (3) Regional wage adjustors based on the Health  
13 Service Areas (HSA) groupings and adjusters in effect on  
14 April 30, 2012 shall be included, except no adjuster shall  
15 be lower than 1.0.

16 (4) Case mix index shall be assigned to each resident  
17 class based on the Centers for Medicare and Medicaid  
18 Services staff time measurement study in effect on July 1,  
19 2013, utilizing an index maximization approach.

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

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

25 (1) Base rate spending pool shall be:

26 (A) The base year resident days which are

1           calculated by multiplying the number of Medicaid  
2           residents in each nursing home as indicated in the MDS  
3           data defined in paragraph (4) by 365.

4           (B) Each facility's nursing component per diem in  
5           effect on July 1, 2012 shall be multiplied by  
6           subsection (A).

7           (C) Thirteen million is added to the product of  
8           subparagraph (A) and subparagraph (B) to adjust for  
9           the exclusion of nursing homes defined in paragraph  
10          (5).

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

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

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

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

26               (D) The sum of the products calculated for each

1 nursing home in subparagraphs (A) through (C) above  
2 shall be the base year case mix, rate adjusted  
3 weighted days.

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

5 (A) on January 1, 2014 shall be the quotient of the  
6 paragraph (1) divided by the sum calculated under  
7 subparagraph (D) of paragraph (2); and

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

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

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

20 (e) Beginning July 1, 2014, the Department shall allocate  
21 funding in the amount up to \$10,000,000 for per diem add-ons to  
22 the RUGS methodology for dates of service on and after July 1,  
23 2014:

24 (1) \$0.63 for each resident who scores in I4200  
25 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

26 (2) \$2.67 for each resident who scores either a "1" or

1 "2" in any items S1200A through S1200I and also scores in  
2 RUG groups PA1, PA2, BA1, or BA2.

3 (e-1) (Blank).

4 (e-2) For dates of services beginning January 1, 2014, the  
5 RUG-IV nursing component per diem for a nursing home shall be  
6 the product of the statewide RUG-IV nursing base per diem  
7 rate, the facility average case mix index, and the regional  
8 wage adjustor. Transition rates for services provided between  
9 January 1, 2014 and December 31, 2014 shall be as follows:

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

14 (A) The nursing component rate in effect July 1,  
15 2012; plus

16 (B) The difference of the RUG-IV nursing component  
17 per diem calculated for the current quarter minus the  
18 nursing component rate in effect July 1, 2012  
19 multiplied by 0.88.

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

24 (A) The nursing component rate in effect July 1,  
25 2012; plus

26 (B) The difference of the RUG-IV nursing component

1 per diem calculated for the current quarter minus the  
2 nursing component rate in effect July 1, 2012  
3 multiplied by 0.13.

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

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

16 (1) Individual nursing rates for residents classified  
17 in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter  
18 ending March 31, 2012 shall be reduced by 10%;

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

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

23 (h) Notwithstanding any other provision of this Code, on  
24 and after July 1, 2012, nursing facilities designated by the  
25 Department of Healthcare and Family Services as "Institutions  
26 for Mental Disease" and "Institutions for Mental Disease" that

1 are facilities licensed under the Specialized Mental Health  
2 Rehabilitation Act of 2013 shall have the nursing,  
3 socio-developmental, capital, and support components of their  
4 reimbursement rate effective May 1, 2011 reduced in total by  
5 2.7%.

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

11 (j) Notwithstanding any other provision of law, subject to  
12 federal approval, effective July 1, 2019, sufficient funds  
13 shall be allocated for changes to rates for facilities  
14 licensed under the Nursing Home Care Act as skilled nursing  
15 facilities or intermediate care facilities for dates of  
16 services on and after July 1, 2019: (i) to establish a per diem  
17 add-on to the direct care per diem rate not to exceed  
18 \$70,000,000 annually in the aggregate taking into account  
19 federal matching funds for the purpose of addressing the  
20 facility's unique staffing needs, adjusted quarterly and  
21 distributed by a weighted formula based on Medicaid bed days  
22 on the last day of the second quarter preceding the quarter for  
23 which the rate is being adjusted; and (ii) in an amount not to  
24 exceed \$170,000,000 annually in the aggregate taking into  
25 account federal matching funds to permit the support component  
26 of the nursing facility rate to be updated as follows:

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

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

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

16          To implement item (i) in this subsection, facilities shall  
17          file quarterly reports documenting compliance with its  
18          annually approved staffing plan, which shall permit compliance  
19          with Section 3-202.05 of the Nursing Home Care Act. A facility  
20          that fails to meet the benchmarks and dates contained in the  
21          plan may have its add-on adjusted in the quarter following the  
22          quarterly review. Nothing in this Section shall limit the  
23          ability of the facility to appeal a ruling of non-compliance  
24          and a subsequent reduction to the add-on. Funds adjusted for  
25          noncompliance shall be maintained in the Long-Term Care  
26          Provider Fund and accounted for separately. At the end of each



1 fiscal year, these funds shall be made available to facilities  
2 for special staffing projects.

3 In order to provide for the expeditious and timely  
4 implementation of the provisions of Public Act 101-10 ~~this~~  
5 ~~amendatory Act of the 101st General Assembly~~, emergency rules  
6 to implement any provision of Public Act 101-10 ~~this~~  
7 ~~amendatory Act of the 101st General Assembly~~ may be adopted in  
8 accordance with this subsection by the agency charged with  
9 administering that provision or initiative. The agency shall  
10 simultaneously file emergency rules and permanent rules to  
11 ensure that there is no interruption in administrative  
12 guidance. The 150-day limitation of the effective period of  
13 emergency rules does not apply to rules adopted under this  
14 subsection, and the effective period may continue through June  
15 30, 2021. The 24-month limitation on the adoption of emergency  
16 rules does not apply to rules adopted under this subsection.  
17 The adoption of emergency rules authorized by this subsection  
18 is deemed to be necessary for the public interest, safety, and  
19 welfare.

20 (k) ~~(j)~~ During the first quarter of State Fiscal Year  
21 2020, the Department of Healthcare of Family Services must  
22 convene a technical advisory group consisting of members of  
23 all trade associations representing Illinois skilled nursing  
24 providers to discuss changes necessary with federal  
25 implementation of Medicare's Patient-Driven Payment Model.  
26 Implementation of Medicare's Patient-Driven Payment Model

1 shall, by September 1, 2020, end the collection of the MDS data  
2 that is necessary to maintain the current RUG-IV Medicaid  
3 payment methodology. The technical advisory group must  
4 consider a revised reimbursement methodology that takes into  
5 account transparency, accountability, actual staffing as  
6 reported under the federally required Payroll Based Journal  
7 system, changes to the minimum wage, adequacy in coverage of  
8 the cost of care, and a quality component that rewards quality  
9 improvements.

10 (Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19;  
11 revised 9-18-19.)

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