SB2995

LRB10222475KTG31615b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB2995

Introduced 1/5/2022, by Sen. Ann Gillespie

SYNOPSIS AS INTRODUCED:

See Index

Amends the Nurse Agency Licensing Act. Prohibits nurse agencies from entering into covenants not to compete with nurses and certified nurse aides who are employed by the agencies. Provides that a supplemental healthcare staffing agency must not bill nor receive payments from a licensed health care facility at a rate higher than 130% of the sum of total compensation plus associated payroll taxes for applicable employee classifications. Provides that the maximum charge must include all charges for administrative fees, contract fees, or other special charges in addition to compensation for the temporary nursing pool personnel supplied to a health care facility. Amends the Illinois Public Aid Code. Provides that is shall be a matter of State policy that the Department of Healthcare and Family Services shall set nursing facility rates, by rule, utilizing an evidence-based methodology that rewards appropriate staffing, quality-of-life improvements for nursing facility residents, and the reduction of racial inequities and health disparities for nursing facility residents enrolled in Medicaid. Contains provisions concerning the Patient Driven Payment Model for nursing services reimbursements; utilization of the Staff Time and Resource Intensity Verification study; the statewide base rate for certain dates of service; the establishment of a variable per diem add-on for nursing facilities with specified staffing levels; directed payments to improve the quality of care delivered by nursing facilities; occupied bed tax amounts beginning January 1, 2022, emergency rules; and other matters. Schedules for repeal on July 1, 2024 the Nursing Home License Fee Article of the Code. Amends the Illinois Administrative Procedure Act. Permits the Department of Healthcare and Family Services to adopt emergency rules to implement certain changes made by the amendatory Act.

LRB102 22475 KTG 31615 b

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 5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.20 as follows:

(5 ILCS 100/5-45.20 new)

Sec. 5-45.20. Emergency rulemaking; nursing facility payment rates. To provide for the expeditious and timely implementation of changes made to Section 5-5.2 of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly, emergency rules implementing such changes may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services. 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 on January 1, 2023.

Section 10. The Nurse Agency Licensing Act is amended by changing Sections 3 and 14 as follows:

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

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

(a) "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.

(b) "Department" means the Department of Labor.

(c) "Director" means the Director of Labor.

(d) "Health care facility" is defined as in Section 3 of the Illinois Health Facilities Planning Act, as now or hereafter amended.

(e) "Licensee" means any nursing agency which is properly licensed under this Act.

(f) "Nurse" means a registered nurse or a licensed practical nurse as defined in the Nurse Practice Act.

(g) "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.

(h) "Covenant not to compete" means an agreement between an employer and an employee that restricts such employee from

performing:

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

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

(3) work for another employer that is similar to such employee's work for the employer included as a party to the agreement.

(Source: P.A. 98-104, eff. 7-22-13; 99-180, eff. 7-29-15.)

(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; and (2) the development of personnel policies which include 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.

(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, 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 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 who are employed by the agencies. After the effective date of this amendatory Act of the 102nd General Assembly, a covenant not to compete entered into between a nurse agency and a certified nurse aide is illegal and void.

(h) Maximum charges. A supplemental healthcare staffing

agency must not bill nor receive payments from a health care facility licensed by the State at a rate higher than 130% of the sum of total compensation plus associated payroll taxes for applicable employee classifications. Agencies must submit a confidential report to the Department of Employment Security on a quarterly basis the sum of total compensation plus associated payroll taxes for all applicable employee classifications, and shall separately include in this report the total revenue received from health care facilities licensed by the State for the same period for these employees, thereby enabling the Department's calculation of the ratio of these 2 totals. This ratio shall be used by the Department to determine compliance with this maximum charge provision, and the veracity of the underlying data shall be subject to audit by the Department as well as by the Auditor General. For purposes of this subsection, total compensation shall include, at a minimum, wages defined as hourly rate of pay and shift differential, including weekend shift differential and overtime.

The maximum charge must include all charges for administrative fees, contract fees, or other special charges in addition to compensation for the temporary nursing pool personnel supplied to a health care facility. A health care facility that pays for the actual travel and housing costs for supplemental healthcare staffing agency staff working at the facility and that pays these costs to the employee, the

agency, or another vendor, is not required to count these costs as total compensation.

(Source: P.A. 86-817.)

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-5.2, 5B-2, 5B-4, 5B-5, 5B-8, 5E-10, and by adding Section 5E-20 as follows:

(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.

(b-1) It shall be a matter of State policy that the Department shall set nursing facility rates, by rule, utilizing an evidence-based methodology that rewards appropriate staffing, quality-of-life improvements for nursing facility residents, and the reduction of racial inequities and health disparities for nursing facility residents enrolled in Medicaid.

(c) (Blank). ~~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 Resource Utilization Groups (RUGs) has been fully operationalized, which shall take effect for services provided on or after January 1, 2014.~~

(d) The new nursing services reimbursement methodology utilizing the Patient Driven Payment Model ~~RUG-IV 48 grouper model~~, which shall be referred to as the PDPM ~~RUGs~~ reimbursement system, taking effect January 1, 2022, upon federal approval by the Centers for Medicare and Medicaid Services ~~2014~~, shall be based on the following:

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

(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 January 1, 2022 ~~April 30, 2012~~ shall be included, except no adjuster shall be lower than 1.0.

(4) PDPM nursing case-mix indices in effect on May 1, 2021 ~~Case mix index~~ shall be assigned to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study called Staff Time and Resource Intensity Verification (STRIVE) ~~in effect on July 1, 2013~~, adjusted by a uniform multiplier to achieve the same statewide case mix index value observed for the quarter beginning April 1, 2021 while holding PA1, PA2, BA1, and BB1 resident classes at the level applicable under the RUG-IV payment model prior to January 1, 2022 ~~utilizing an index maximization approach~~.

(5) (Blank). ~~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 statewide base rate for dates of service before January 1, 2022 shall be $85.25, and thereafter shall be no less than $90.25.

(7) The Department shall establish a variable per diem add-on based on information from the most recent available federal staffing report, currently the Payroll Based Journal, adjusted for acuity if applicable using the same quarter's MDS. The variable per diem add-on shall be paid only to facilities with at least 70% of the staffing indicated by the STRIVE study. For facilities at 70% of the staffing indicated by the STRIVE study, those

facilities shall be paid a per diem add-on of $9, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem of $14.88. For facilities with at least 80% of the staffing indicated by the STRIVE study, those facilities shall be paid a per diem add-on of $14.88, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem add-on of $23.80. For facilities with at least 92% of the staffing indicated by the STRIVE study, those facilities shall be paid a per diem add-on of $23.80, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem add-on of $29.75. For facilities with at least 100% of the staffing indicated by the STRIVE study, those facilities shall be paid a per diem add-on of $29.75, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem add-on of $35.70. For facilities with at least 110% of the staffing indicated by the STRIVE study, those facilities shall be paid a per diem add-on of $35.70, increasing by equivalent steps for each whole percentage point of improvement until the facilities reach a per diem add-on of $38.68. For facilities with 125% of the staffing indicated by the STRIVE study or more, those facilities shall be paid a per diem add-on of $38.68. The Department

shall establish, by rule, a limit of not more than a 5 percentage point drop per once-consecutive quarter in the STRIVE percentage used to determine the variable per diem add-on.

(d-1) (Blank). ~~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); 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 through December 31, 2021, 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.

(3) Beginning on and after January 1, 2022, the Department shall allocate funding, by rule, for per diem add-ons to the PDPM methodology for each resident with a diagnosis of Alzheimer's disease.

(e-1) (Blank).

(e-2) (Blank). ~~For dates of services beginning January 1, 2014, 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. Transition rates for services provided between January 1, 2014 and December 31, 2014 shall be as follows:~~

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

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

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

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

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

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

~~(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) (Blank); ~~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) (Blank); ~~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) 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 December 31, 2021 or upon implementation of the variable per diem add-on for staffing under paragraph (7) of subsection (d), whichever is later, 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 January 1, 2022, or upon implementation of the variable per diem add-on for staffing under paragraph (7) of subsection (d), whichever is later, the annual $70,000,000 described in the preceding sentence shall be dedicated to the variable per diem add-on for staffing under paragraph (7) 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 ~~and taking into account subsection (i)~~.

(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.

In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 102nd General Assembly, emergency rules to implement any provision of this amendatory Act of the 102nd General Assembly may be adopted in accordance with this subsection by the agency charged with administering that provision or initiative. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection. The adoption of emergency rules authorized by this subsection is deemed to be necessary for the public interest, safety, and welfare.

~~To implement item (i) in this subsection, facilities shall file quarterly reports documenting compliance with its annually approved staffing plan, which shall permit compliance with Section 3-202.05 of the Nursing Home Care Act. A facility~~

~~that fails to meet the benchmarks and dates contained in the plan may have its add-on adjusted in the quarter following the quarterly review. Nothing in this Section shall limit the ability of the facility to appeal a ruling of non-compliance and a subsequent reduction to the add-on. Funds adjusted for noncompliance shall be maintained in the Long Term Care Provider Fund and accounted for separately. At the end of each fiscal year, these funds shall be made available to facilities for special staffing projects.~~

~~In order to provide for the expeditious and timely implementation of the provisions of Public Act 101-10, emergency rules to implement any provision of Public Act 101-10 may be adopted in accordance with this subsection by the agency charged with administering that provision or initiative. The agency shall simultaneously file emergency rules and permanent rules to ensure that there is no interruption in administrative guidance. The 150 day limitation of the effective period of emergency rules does not apply to rules adopted under this subsection, and the effective period may continue through June 30, 2021. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection. The adoption of emergency rules authorized by this subsection is deemed to be necessary for the public interest, safety, and welfare.~~

(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 directed 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 Section shall be construed to limit the quality of care directed payments to $70,000,000, and in the case that quality of care has improved across nursing facilities, the Department shall adjust those directed payments accordingly. The quality payment methodology described in this Section must be used for at least the first 2 quarters in calendar year 2022. Beginning with the quarter starting July 1, 2022, 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. "LTS quality star rating" means the long 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 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.

(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 to a quality review committee established by the Department consisting of associations representing long-term care providers, consumer advocates, organizations representing workers of long-term care facilities, and payors.

(F) The Department shall disburse quality pool payments from the Long-Term Care Provider Fund on either a monthly or daily 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) In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 102nd General Assembly, emergency rules to implement any provision of this amendatory Act of the 102nd General Assembly may be adopted in accordance with this subsection by the agency charged with administering that provision or initiative. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection. The adoption of emergency rules authorized by this subsection is deemed to be necessary for the public interest, safety, and welfare.

(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.)

(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 December 31, 2021, 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, beginning January 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 initial schedule of occupied bed tax amounts:

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

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

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

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

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

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

(7) Any nonprofit nursing facilities without Medicaid-certified beds, $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.

Each facility's paid Medicaid resident days per annum shall be updated annually for the purpose of determining the appropriate tax rate.

Implementation of the assessment described in this subsection shall be subject to federal approval by the Centers for Medicare and Medicaid Services.

(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 ~~5-5.4~~ 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. 96-1530, eff. 2-16-11; 97-10, eff. 6-14-11; 97-584, eff. 8-26-11.)

(305 ILCS 5/5B-4) (from Ch. 23, par. 5B-4)

Sec. 5B-4. Payment of assessment; penalty.

(a) The assessment imposed by Section 5B-2 shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has delayed payment due to the State's failure to reimburse for services rendered may request an extension on the due date for payment pursuant to subsection (b) and shall pay the assessment within 30 days of reimbursement by the Department. The Illinois Department may provide that county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their assessment obligation by certifying to the Illinois Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the assessment.

(a-5) The Illinois Department shall provide for an electronic submission process for each long-term care facility to report at a minimum the number of occupied bed days of the long-term care facility for the reporting period and other

reasonable information the Illinois Department requires for the administration of its responsibilities under this Code. Beginning July 1, 2013, a separate electronic submission shall be completed for each long-term care facility in this State operated by a long-term care provider. The Illinois Department shall provide a self-reporting notice of the assessment form that the long-term care facility completes for the required period and submits with its assessment payment to the Illinois Department. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long-term care facilities.

(b) The Illinois Department is authorized to establish delayed payment schedules for long-term care providers that are unable to make assessment payments when due under this Section due to financial difficulties, as determined by the Illinois Department. The Illinois Department may not deny a request for delay of payment of the assessment imposed under this Article if the long-term care provider has not been paid for services provided during the month on which the assessment is levied ~~or the Medicaid managed care organization has not been paid by the State~~.

(c) If a long-term care provider fails to pay the full amount of an assessment payment when due (including any extensions granted under subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 a penalty

assessment equal to the lesser of (i) 5% of the amount of the assessment payment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter or (ii) 100% of the assessment payment amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid assessment payment amounts (rather than to penalty or interest), beginning with the most delinquent assessment payments. Payment cycles of longer than 60 days shall be one factor the Director takes into account in granting a waiver under this Section.

(c-5) If a long-term care facility fails to file its assessment bill with payment, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due. After July 1, 2013, no penalty shall be assessed under this Section if the Illinois Department does not provide a process for the electronic submission of the information required by subsection (a-5).

(d) Nothing in this amendatory Act of 1993 shall be construed to prevent the Illinois Department from collecting all amounts due under this Article pursuant to an assessment imposed before the effective date of this amendatory Act of 1993.

(e) Nothing in this amendatory Act of the 96th General Assembly shall be construed to prevent the Illinois Department

from collecting all amounts due under this Code pursuant to an assessment, tax, fee, or penalty imposed before the effective date of this amendatory Act of the 96th General Assembly.

(f) No installment of the assessment imposed by Section 5B-2 shall be due and payable 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 ~~5-5.4~~ 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 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. Upon notification to the Department of approval of the payment methodologies required under Section 5-5.2 ~~5-5.4~~ of this Code and the waivers granted under 42 CFR 433.68, all installments otherwise due under Section 5B-4 prior to the date of notification shall be due and payable to the Department upon written direction from the Department within 90 days after issuance by the Comptroller of the payments required under Section 5-5.2 ~~5-5.4~~ of this Code.

(Source: P.A. 100-501, eff. 6-1-18; 101-649, eff. 7-7-20.)

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

Sec. 5B-5. Annual reporting; penalty; maintenance of records.

(a) After December 31 of each year, and on or before March 31 of the succeeding year, every long-term care provider subject to assessment under this Article shall file a report with the Illinois Department. The report shall be in a form and manner prescribed by the Illinois Department and shall state the revenue received by the long-term care provider, reported in such categories as may be required by the Illinois Department, and other reasonable information the Illinois Department requires for the administration of its responsibilities under this Code.

(b) If a long-term care provider operates or maintains more than one long-term care facility in this State, the provider may not file a single return covering all those long-term care facilities, but shall file a separate return for each long-term care facility and shall compute and pay the assessment for each long-term care facility separately.

(c) Notwithstanding any other provision in this Article, in the case of a person who ceases to operate or maintain a long-term care facility in respect of which the person is subject to assessment under this Article as a long-term care provider, the person shall file a final, amended return with the Illinois Department not more than 90 days after the cessation reflecting the adjustment and shall pay with the final return the assessment for the year as so adjusted (to the extent not previously paid). If a person fails to file a final amended return on a timely basis, there shall, unless waived

by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due.

(d) Notwithstanding any other provision of this Article, a provider who commences operating or maintaining a long-term care facility that was under a prior ownership and remained licensed by the Department of Public Health shall notify the Illinois Department of any ~~the~~ change in ownership regardless of percentage, and shall be responsible to immediately pay any prior amounts owed by the facility. In addition, within 90 days after the effective date of this amendatory Act of the 102nd General Assembly, all providers operating or maintaining a long-term care facility shall notify the Illinois Department of all individual owners and any individuals or organizations that are part of a limited liability company with ownership of that facility and the percentage ownership of each owner. This ownership reporting requirement does not include individual shareholders in a publicly held corporation.

(e) The Department shall develop a procedure for sharing with a potential buyer of a facility information regarding outstanding assessments and penalties owed by that facility.

(f) In the case of a long-term care provider existing as a corporation or legal entity other than an individual, the return filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

(g) If a long-term care provider fails to file its return on or before the due date of the return, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 a penalty assessment equal to 25% of the assessment imposed for the year. After July 1, 2013, no penalty shall be assessed if the Illinois Department has not established a process for the electronic submission of information.

(h) Every long-term care provider subject to assessment under this Article shall keep records and books that will permit the determination of occupied bed days on a calendar year basis. All such books and records shall be kept in the English language and shall, at all times during business hours of the day, be subject to inspection by the Illinois Department or its duly authorized agents and employees.

(i) The Illinois Department shall establish a process for long-term care providers to electronically submit all information required by this Section no later than July 1, 2013.

(Source: P.A. 96-1530, eff. 2-16-11; 97-403, eff. 1-1-12; 97-813, eff. 7-13-12.)

(305 ILCS 5/5B-8) (from Ch. 23, par. 5B-8)

Sec. 5B-8. Long-Term Care Provider Fund.

(a) There is created in the State Treasury the Long-Term Care Provider Fund. Interest earned by the Fund shall be

credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

(b) The Fund is created for the purpose of receiving and disbursing moneys in accordance with this Article. Disbursements from the Fund shall be made only as follows:

(1) For payments to nursing facilities, including county nursing facilities but excluding State-operated facilities, under Title XIX of the Social Security Act and Article V of this Code.

(1.5) For payments to managed care organizations as defined in Section 5-30.1 of this Code.

(2) For the reimbursement of moneys collected by the Illinois Department through error or mistake.

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing the activities authorized by this Article.

(3.5) For reimbursement of expenses incurred by long-term care facilities, and payment of administrative expenses incurred by the Department of Public Health, in relation to the conduct and analysis of background checks for identified offenders under the Nursing Home Care Act.

(4) For payments of any amounts that are reimbursable to the federal government for payments from this Fund that are required to be paid by State warrant.

(5) For making transfers to the General Obligation

Bond Retirement and Interest Fund, as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

(6) For making transfers, at the direction of the Director of the Governor's Office of Management and Budget during each fiscal year beginning on or after July 1, 2011, to other State funds in an annual amount of $20,000,000 of the tax collected pursuant to this Article for the purpose of enforcement of nursing home standards, support of the ombudsman program, and efforts to expand home and community-based services. No transfer under this paragraph shall occur until (i) the payment methodologies created by Public Act 96-1530 under Section 5-5.4 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 (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

Disbursements from the Fund, other than transfers made pursuant to paragraphs (5) and (6) of this subsection, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Illinois Department from the long-term care provider assessment imposed by this Article.

(2) All federal matching funds received by the Illinois Department as a result of expenditures made from the Fund ~~by the Illinois Department that are attributable to moneys deposited in the Fund~~.

(3) Any interest or penalty levied in conjunction with the administration of this Article.

(4) (Blank).

(5) All other monies received for the Fund from any other source, including interest earned thereon.

(Source: P.A. 96-1530, eff. 2-16-11; 97-584, eff. 8-26-11.)

(305 ILCS 5/5E-10)

Sec. 5E-10. Fee. Through December 31, 2021 or upon federal approval by the Centers for Medicare and Medicaid Services of the long-term care provider assessment described in subsection (a-1) of Section 5B-2 of this Code, whichever is later, every ~~Every~~ nursing home provider shall pay to the Illinois Department, on or before September 10, December 10, March 10, and June 10, a fee in the amount of $1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. This fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home

provider. All fees received by the Illinois Department under this Section shall be deposited into the Long-Term Care Provider Fund. This Section 5E-10 is repealed on December 31, 2023.

(Source: P.A. 88-88; 89-21, eff. 7-1-95.)

(305 ILCS 5/5E-20 new)

Sec. 5E-20. Repealer. This Article 5E is repealed on July 1, 2024.

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Statutes amended in order of appearance

5 ILCS 100/5-45.20 new	
225 ILCS 510/3	from Ch. 111, par. 953
225 ILCS 510/14	from Ch. 111, par. 964
305 ILCS 5/5-5.2	from Ch. 23, par. 5-5.2
305 ILCS 5/5B-2	from Ch. 23, par. 5B-2
305 ILCS 5/5B-4	from Ch. 23, par. 5B-4
305 ILCS 5/5B-5	from Ch. 23, par. 5B-5
305 ILCS 5/5B-8	from Ch. 23, par. 5B-8
305 ILCS 5/5E-10	
305 ILCS 5/5E-20 new	