Sen. Heather A. Steans

Filed: 4/7/2016

AMENDMENT TO SENATE BILL 419

AMENDMENT NO. _____. Amend Senate Bill 419 by replacing everything after the enacting clause with the following:

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

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

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

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

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

(5) Policy research has noted the significant positive

relationship between nursing home staffing levels and quality of care.

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

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

Section 5. The Illinois Public Aid Code is amended by changing Section 5-5.2 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.

(c) 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 RUG-IV 48 grouper model, which shall be referred to as the RUGs reimbursement system, taking effect January 1, 2014, shall be based on the following:

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

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

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

(d-1) Calculation of base year Statewide RUG-IV nursing

base per diem rate, for dates of service beginning January 1, 2014 through December 31, 2016.

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

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

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

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014 through December 31, 2016, 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.

(e-3) Calculation of facility-specific RUG-IV nursing component per diem rate for dates of service beginning January 1, 2017.

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

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

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

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

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

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

(iv) 1.45 for a facility with a total per resident per day staffing wage cost greater than or equal to level 3; or

(v) 0.80 for a facility without data necessary to calculate the facility's specific total per resident per day staffing wage cost as defined in paragraph (2) of this subsection.

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

(D) The ratio of actual staffing hours to total expected staffing hours adjuster which is assigned based on each facility's ratio as defined in paragraph (5) of this subsection. The facilities are divided into 4 quartiles sorted from lowest to highest based on the facility's ratio. The quartile with the lowest ratios is quartile 1 and the quartile with the highest ratios

is quartile 4 with quartile 2 and quartile 3 assigned based on the ratios in those quartiles in relation to lowest and highest quartiles. Facilities without reported data are assigned to quartile 3. The quartiles are calculated quarterly during regular rate updates. The adjuster for each quartile is as follows:

(i) 0.65 for facilities in quartile 1;

(ii) the ratio defined in paragraph (5) of this subsection for facilities in quartile 2 and 3; or

(iii) 1.00 for facilities in quartile 4.

(2) The staffing and wage adjuster under subparagraph (B) of paragraph (1) of this subsection must be updated each quarter using the staffing hours and wage data from Payroll Benefit Journal data collected by the Centers for Medicare and Medicaid Services for the same time period of MDS data used to calculate the RUG-IV acuity case weight. For the purposes of this Section, each facility's "total per resident per day staffing wage cost" is calculated by summing:

(A) The product of registered nurses' hours worked per resident day multiplied by the reported hourly wage. For the Director of Nursing only the number of hours allowed under Section 3-202.05 of the Nursing Home Care Act for the calculation of staffing ratios may be included; plus

(B) The product of licensed practical nurses'

worked hours per resident day multiplied by the reported hourly wage; plus

(C) The product of certified nurse assistants' hours worked per resident day multiplied by the reported hourly wage; plus

(D) For all other staff considered direct care staff under staffing ratios described in Section 3-202.05 of the Nursing Home Care Act, the product of each remaining direct care staff type hours worked per resident day multiplied by the reported hourly wage for the direct care staff category at the same levels allowed under the staffing ratios under Section 3-202.05 of the Nursing Home Care Act.

(3) The levels used to assign the staffing and wage adjuster under subparagraph (B) of paragraph (1) of this subsection shall be calculated using the staffing ratios required under Section 3-202.05 of the Nursing Home Care Act multiplied by the Illinois mean hourly wage for the equivalent occupational code and title assigned by the U.S. Bureau of Labor Statistics and reported in the May 2014 State Occupational Employment and Wage Estimates for Illinois. The Department may, as established by rule, use more current data from the same data set when made available. The levels are:

(A) Level 1 is equal to the sum of:

(i) The product of 10% of the minimum staffing

hours per resident day for intermediate care under Section 3-202.05 of the Nursing Home Care Act multiplied by the Illinois mean hourly wage for registered nurses occupation code 29-1141 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection; plus

(ii) The product of 15% of the minimum staffing hours per resident day for intermediate care under Section 3-202.05 of the Nursing Home Care Act multiplied by the Illinois mean hourly wage for licensed practical nurses occupation code 29-2061 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection; plus

(iii) The product of 75% of the minimum staffing hours per resident day for intermediate care under Section 3-202.05 of the Nursing Home Care Act multiplied by the Illinois mean hourly wage for nursing assistants occupation code 31-1014 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection.

(B) Level 2 is equal to the sum of:

(i) The product of 10% of the minimum staffing hours per resident day for skilled care under Section 3-202.05 of the Nursing Home Care Act

multiplied by the Illinois mean hourly wage for registered nurses occupation code 29-1141 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection; plus

(ii) The product of 15% of the minimum staffing hours per resident day for skilled care under Section 3-202.05 of the Nursing Home Care Act multiplied by the Illinois mean hourly wage for licensed practical nurses occupation code 29-2061 from the U.S. Bureau of Labor Statistics set described in paragraph (3) of this subsection; plus

(iii) The product of 75% of the minimum staffing hours per resident day for skilled care under Section 3-202.05 of the Nursing Home Care Act multiplied by the Illinois mean hourly wage for nursing assistants occupation code 31-1014 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection.

(C) Level 3 is equal to the sum of:

(i) The product of .84 staffing hours per resident day multiplied by the Illinois mean hourly wage for registered nurses occupation code 29-1141 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection; plus

(ii) The product of .84 staffing hours per resident day multiplied by the Illinois mean hourly wage for licensed practical nurses occupation code 29-2061 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection; plus

(iii) The product of 2.46 staffing hours per resident day multiplied by the Illinois mean hourly wage for nursing assistants occupation code 31-1014 from the U.S. Bureau of Labor Statistics data set described in paragraph (3) of this subsection.

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

(5) The facility-specific total ratio of actual staffing hours to total expected staffing hours for the assigned resident specific case weight must be updated each quarter using the staffing hours and wage data from Payroll Benefit Journal data collected by the Centers for Medicare and Medicaid Services for the same time period of MDS data used to calculate the RUG-IV acuity case weight. For each facility the Department must calculate the total hours worked per resident day for direct care staff allowed by the staffing ratios under Section 3-202.05 of the Nursing Home Care Act and divide that value by the sum of staffing

hours per resident day assigned to each resident based on the sum of the Resident Specific Time and Direct Non-Resident Specific Time for the resident's RUG-IV group. This is the same methodology for the Medicare 5-star rating program calculation of the expected staffing hours per resident day used by the Centers for Medicare and Medicaid Services, except that the Centers for Medicare and Medicaid Services uses RUG-III groupings.

(6) If the Payroll Benefit Journal data collected by the Centers for Medicare and Medicaid Services is not available, the Department must use the most recent cost reporting data reported to the Department and the most recent survey data posted to the Centers for Medicare and Medicaid Services' Nursing Home Compare website. The Department must use the Payroll Benefit Journal data collected by the Centers for Medicare and Medicaid Services once the data is available.

(e-4) Budget stability beginning January 1, 2017.

(1) Beginning January 1, 2017 and annually thereafter, the Department may adjust, by administrative rule and within the parameters established under this subsection (e-4), the staffing and wage adjuster described in subparagraph (B) of paragraph (1) of subsection (e-3) and the ratio of actual staffing hours to the total expected staffing hours adjuster described in subparagraph (D) of paragraph (1) of subsection (e-3) for the purpose of

keeping liability created by the facility-specific RUG-IV nursing component per diem rates stable as defined in paragraph (2) and paragraph (3) of this subsection (e-4).

(2) Budget stability for facility-specific RUG-IV nursing component per diem rates effective January 1, 2017. If the aggregate budget stability ratio calculated under paragraph (4) of this subsection is greater than 0.96, then the Department must adjust one or both of the adjusters specified in paragraph (1) of this subsection in order to decrease the ratio to no less than 0.96.

(3) Budget stability for facility-specific RUG-IV nursing component per diem rates effective January 1, 2018 and annually thereafter. If the aggregate budget stability ratio calculated under paragraph (4) of this subsection is between 0.99 and 1.01, the Department must not make any adjustments. If the aggregate budget stability ratio calculated under paragraph (4) of this subsection is less than 0.99, then the Department must adjust one or both of the adjusters specified in paragraph (1) of this subsection in order to increase the ratio to at least 0.99. If the aggregate budget stability ratio calculated under paragraph (4) of this subsection is greater than 1.01, then the Department must adjust one or both of the adjusters specified in paragraph (1) of this subsection in order to decrease the ratio to at least 1.01, but no less than 1.00.

(4) For the purposes of this Section, the aggregate

budget stability ratio calculated with the numerator described in subparagraph (A) of this paragraph (4) divided by the denominator described in subparagraph (B) of this paragraph (4) is as follows:

(A) Numerator equal to the sum of the following products:

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

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

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

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

(ii) each nursing home's specific rate effective July 1, 2015 under subsection (e-2). This rate does not include the per diem add-ons defined in subsection (e) of this Section.

(5) If adjustments are necessary under this subsection (e-4), the staffing and wage adjuster described in

subparagraph (B) of paragraph (1) of subsection (e-3) must be adjusted within the following parameters:

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

(B) the adjuster for facilities with a total per resident per day staffing wage cost less than level 1 must be lower than the adjusters for the other levels;

(C) the adjuster for facilities with a total per resident per day staffing wage cost less than level 1 must generate an aggregate cost coverage for nursing homes qualifying for that adjuster less than or equal to 70% using the most recent cost data from cost reports filed with the Department. The cost coverage for the nursing homes qualifying for that adjuster must have the lowest cost coverage as compared to the other 3 groups;

(D) the adjusters for the middle 2 levels must generate the best possible aggregate cost coverage for nursing homes qualifying for those adjusters of all the adjusters using the most recent cost data from cost reports filed with the Department; and

(E) the adjuster for facilities with a total per resident per day staffing wage cost greater than level 4 must generate an aggregate cost coverage for nursing homes qualifying for that adjuster less than or equal

to 80% using the most recent cost data from cost reports filed with the Department.

(F) Any limitations in this paragraph (5) based on cost coverage must use the most recent cost data from cost reports filed with the Department and must be calculated after any adjustments have been made to the ratio of actual staffing hours to total expected staffing hours adjuster described in subparagraph (D) of paragraph (1) of subsection (e-3) and limited by paragraph (6) of this subsection (e-4).

(6) If adjustments are necessary under this subsection (e-4), the ratio of actual staffing hours to total expected staffing hours adjuster described in subparagraph (D) of paragraph (1) of subsection (e-3) must be adjusted within the following parameters:

(A) the adjuster for quartile 4 which has the best acuity based staffing ratio must never be less than 1.00;

(B) the adjuster for quartile 1 must be the smallest of all 4 quartile adjusters and must never be greater than 0.65;

(C) the Department may set a specific adjuster for quartile 2 and quartile 3 as opposed to the facility-specific ratio defined in paragraph (5) of subsection (e-3) which is allowed under subparagraph (D) of paragraph (1) of subsection (e-3). If the

Department sets a specific adjuster for quartile 2 or quartile 3, then the adjuster for quartile 3 must not be greater than the adjuster for quartile 4 or less than the adjuster for quartile 2. The adjuster for quartile 2 must not be greater than the adjuster for quartile 3 or less than the adjuster for quartile 1; and

(D) no quartile may have an adjuster greater than 1.00.

(7) For the purposes of this Section, cost coverage for a facility is the facility-specific RUG-IV nursing component per diem rate divided by the healthcare program cost per day. The healthcare program cost per day is calculated using data from cost reports submitted to the Department as required under the Illinois Public Aid Code and the Department's administrative rules. The Department may update the cost report references in this paragraph by administrative rule should the Department's cost report be altered, as long as the updated references result in identification of the identical or equivalent data and does not materially change the resulting calculations. If the Department has made changes from an audit, the Department may use column 10 instead of column 8 of the respective cost report lines cited in this paragraph (7) if the information is made publicly available at the time of making any calculations required in this Section. The

healthcare program cost per day is the quotient of:

(A) the sum of the following costs as reported on schedule V. of the Department's cost report;

(i) the total adjusted health care and programs costs as reported on line 16 column 8; plus

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

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

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

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

(g) Notwithstanding any other provision of this Code, on

and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease", rates effective May 1, 2011 shall be adjusted as follows:

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

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

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

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

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

(j) The Department may adopt rules in accordance with the

Illinois Administrative Procedure Act to implement this Section. However, the requirements under this Section must be implemented by the Department even if the Department has not adopted rules by the implementation date of January 1, 2017.

(Source: P.A. 98-104, Article 6, Section 6-240, eff. 7-22-13; 98-104, Article 11, Section 11-35, eff. 7-22-13; 98-651, eff. 6-16-14; 98-727, eff. 7-16-14; 98-756, eff. 7-16-14; 99-78, eff. 7-20-15.)

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