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 the
13 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,

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) 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.

(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, 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

1 multiplied by 0.13.

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

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

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

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

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

20 (h) Notwithstanding any other provision of this Code, on
21 and after July 1, 2012, nursing facilities designated by the
22 Department of Healthcare and Family Services as "Institutions
23 for Mental Disease" and "Institutions for Mental Disease" that
24 are facilities licensed under the Specialized Mental Health
25 Rehabilitation Act of 2013 shall have the nursing,
26 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) 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.

(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.)

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