AN ACT concerning regulation.

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

Section 1. The Illinois Administrative Procedure Act is amended by adding Section 5-45.35 as follows:

(5 ILCS 100/5-45.35 new)

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

This Section is repealed one year after the effective date of this amendatory Act of the 102nd General Assembly.

Section 5. The Illinois Health Facilities Planning Act is amended by adding Section 8.9a as follows:

(20 ILCS 3960/8.9a new)

Sec. 8.9a. Extension of project completion date. Any party that has previously received approval by the State Board to re-establish a previously discontinued general acute care hospital in accordance with Section 8.9 of this Act shall have the automatic right to extend the project completion date listed by the party in the party's certificate of exemption application by providing notice to the State Board of the new project completion date.

Section 10. The Nursing Home Care Act is amended by changing Section 3-202.05 as follows:

(210 ILCS 45/3-202.05)

Sec. 3-202.05. Staffing ratios effective July 1, 2010 and thereafter.

(a) For the purpose of computing staff to resident ratios, direct care staff shall include:

(1) registered nurses;

(2) licensed practical nurses;

(3) certified nurse assistants;

(4) psychiatric services rehabilitation aides;

(5) rehabilitation and therapy aides;

(6) psychiatric services rehabilitation coordinators;

(7) assistant directors of nursing;

(8) 50% of the Director of Nurses' time; and

(9) 30% of the Social Services Directors' time.

The Department shall, by rule, allow certain facilities subject to 77 Ill. Adm. ~~Admin.~~ Code 300.4000 and following (Subpart S) to utilize specialized clinical staff, as defined in rules, to count towards the staffing ratios.

Within 120 days of June 14, 2012 (the effective date of Public Act 97-689) ~~this amendatory Act of the 97th General Assembly~~, the Department shall promulgate rules specific to the staffing requirements for facilities federally defined as Institutions for Mental Disease. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

Within 120 days of June 14, 2012 (the effective date of Public Act 97-689) ~~this amendatory Act of the 97th General Assembly~~, the Department shall promulgate rules specific to the staffing requirements for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and

any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

(b) (Blank).

(b-5) For purposes of the minimum staffing ratios in this Section, all residents shall be classified as requiring either skilled care or intermediate care.

As used in this subsection:

"Intermediate care" means basic nursing care and other restorative services under periodic medical direction.

"Skilled care" means skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision.

(c) Facilities shall notify the Department within 60 days after July 29, 2010 (the effective date of Public Act 96-1372) ~~this amendatory Act of the 96th General Assembly~~, in a form and manner prescribed by the Department, of the staffing ratios in effect on July 29, 2010 (the effective date of Public Act 96-1372) ~~this amendatory Act of the 96th General Assembly~~ for both intermediate and skilled care and the number of residents receiving each level of care.

(d)(1) (Blank).

(2) (Blank).

(3) (Blank).

(4) (Blank).

(5) Effective January 1, 2014, the minimum staffing ratios

shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care.

(e) Ninety days after June 14, 2012 (the effective date of Public Act 97-689) ~~this amendatory Act of the 97th General Assembly~~, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. These minimum requirements shall remain in effect until an acuity based registered nurse requirement is promulgated by rule concurrent with the adoption of the Resource Utilization Group classification-based payment methodology, as provided in Section 5-5.2 of the Illinois Public Aid Code. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. Notwithstanding this subsection, no staffing requirement in statute in effect on June 14, 2012 (the effective date of Public Act 97-689) ~~this amendatory Act of the 97th General Assembly~~ shall be reduced on account of this subsection.

(f) The Department shall submit proposed rules for adoption by January 1, 2020 establishing a system for determining compliance with minimum staffing set forth in this Section and the requirements of 77 Ill. Adm. Code 300.1230

adjusted for any waivers granted under Section 3-303.1. Compliance shall be determined quarterly by comparing the number of hours provided per resident per day using the Centers for Medicare and Medicaid Services' payroll-based journal and the facility's daily census, broken down by intermediate and skilled care as self-reported by the facility to the Department on a quarterly basis. The Department shall use the quarterly payroll-based journal and the self-reported census to calculate the number of hours provided per resident per day and compare this ratio to the minimum staffing standards required under this Section, as impacted by any waivers granted under Section 3-303.1. Discrepancies between job titles contained in this Section and the payroll-based journal shall be addressed by rule. The manner in which the Department requests payroll-based journal information to be submitted shall align with the federal Centers for Medicare and Medicaid Services' requirements that allow providers to submit the quarterly data in an aggregate manner.

(g) Monetary penalties for non-compliance. The Department shall submit proposed rules for adoption by January 1, 2020 establishing monetary penalties for facilities not in compliance with minimum staffing standards under this Section. Facilities shall be required to comply with the provisions of this subsection beginning January 1, 2025. No monetary penalty may be issued for noncompliance prior to ~~during~~ the revised implementation date ~~period~~, which shall be January 1, 2025

~~July 1, 2020 through December 31, 2021~~. If a facility is found to be noncompliant prior to ~~during~~ the revised implementation date ~~period~~, the Department shall provide a written notice identifying the staffing deficiencies and require the facility to provide a sufficiently detailed correction plan that describes proposed and completed actions the facility will take or has taken, including hiring actions, to address the facility's failure to meet the statutory minimum staffing levels. Monetary penalties shall be imposed beginning no later than July 1, 2025, based on data for the quarter beginning January 1, 2025 through March 31, 2025 ~~January 1, 2022~~ and quarterly thereafter ~~and shall be based on the latest quarter for which the Department has data~~. Monetary penalties shall be established based on a formula that calculates on a daily basis the cost of wages and benefits for the missing staffing hours. All notices of noncompliance shall include the computations used to determine noncompliance and establishing the variance between minimum staffing ratios and the Department's computations. The penalty for the first offense shall be 125% of the cost of wages and benefits for the missing staffing hours. The penalty shall increase to 150% of the cost of wages and benefits for the missing staffing hours for the second offense and 200% the cost of wages and benefits for the missing staffing hours for the third and all subsequent offenses. The penalty shall be imposed regardless of whether the facility has committed other violations of this Act during

the same period that the staffing offense occurred. The penalty may not be waived, but the Department shall have the discretion to determine the gravity of the violation in situations where there is no more than a 10% deviation from the staffing requirements and make appropriate adjustments to the penalty. The Department is granted discretion to waive the penalty when unforeseen circumstances have occurred that resulted in call-offs of scheduled staff. This provision shall be applied no more than 6 times per quarter. Nothing in this Section diminishes a facility's right to appeal the imposition of a monetary penalty. No facility may appeal a notice of noncompliance issued during the revised implementation period. (Source: P.A. 101-10, eff. 6-5-19; 102-16, eff. 6-17-21; revised 2-28-22.)

Section 15. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Section 1-102 as follows:

(210 ILCS 49/1-102)

Sec. 1-102. Definitions. For the purposes of this Act, unless the context otherwise requires:

"Abuse" means any physical or mental injury or sexual assault inflicted on a consumer other than by accidental means in a facility.

"Accreditation" means any of the following:

(1) the Joint Commission;

(2) the Commission on Accreditation of Rehabilitation Facilities;

(3) the Healthcare Facilities Accreditation Program; or

(4) any other national standards of care as approved by the Department.

"APRN" means an Advanced Practice Registered Nurse, nationally certified as a mental health or psychiatric nurse practitioner and licensed under the Nurse Practice Act.

"Applicant" means any person making application for a license or a provisional license under this Act.

"Consumer" means a person, 18 years of age or older, admitted to a mental health rehabilitation facility for evaluation, observation, diagnosis, treatment, stabilization, recovery, and rehabilitation.

"Consumer" does not mean any of the following:

(i) an individual requiring a locked setting;

(ii) an individual requiring psychiatric hospitalization because of an acute psychiatric crisis;

(iii) an individual under 18 years of age;

(iv) an individual who is actively suicidal or violent toward others;

(v) an individual who has been found unfit to stand trial <u>and is currently subject to a court order requiring placement in secure inpatient care in the custody of the Department of Human Services pursuant to Section 104-17 of</u>

the Code of Criminal Procedure of 1963;

(vi) an individual who has been found not guilty by reason of insanity and is currently subject to a court order requiring placement in secure inpatient care in the custody of the Department of Human Services pursuant to Section 5-2-4 of the Unified Code of Corrections ~~based on committing a violent act, such as sexual assault, assault with a deadly weapon, arson, or murder~~;

(vii) an individual subject to temporary detention and examination under Section 3-607 of the Mental Health and Developmental Disabilities Code;

(viii) an individual deemed clinically appropriate for inpatient admission in a State psychiatric hospital; and

(ix) an individual transferred by the Department of Corrections pursuant to Section 3-8-5 of the Unified Code of Corrections.

"Consumer record" means a record that organizes all information on the care, treatment, and rehabilitation services rendered to a consumer in a specialized mental health rehabilitation facility.

"Controlled drugs" means those drugs covered under the federal Comprehensive Drug Abuse Prevention Control Act of 1970, as amended, or the Illinois Controlled Substances Act.

"Department" means the Department of Public Health.

"Discharge" means the full release of any consumer from a facility.

"Drug administration" means the act in which a single dose of a prescribed drug or biological is given to a consumer. The complete act of administration entails removing an individual dose from a container, verifying the dose with the prescriber's orders, giving the individual dose to the consumer, and promptly recording the time and dose given.

"Drug dispensing" means the act entailing the following of a prescription order for a drug or biological and proper selection, measuring, packaging, labeling, and issuance of the drug or biological to a consumer.

"Emergency" means a situation, physical condition, or one or more practices, methods, or operations which present imminent danger of death or serious physical or mental harm to consumers of a facility.

"Facility" means a specialized mental health rehabilitation facility that provides at least one of the following services: (1) triage center; (2) crisis stabilization; (3) recovery and rehabilitation supports; or (4) transitional living units for 3 or more persons. The facility shall provide a 24-hour program that provides intensive support and recovery services designed to assist persons, 18 years or older, with mental disorders to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. It includes facilities that meet the following criteria:

(1) 100% of the consumer population of the facility

has a diagnosis of serious mental illness;

(2) no more than 15% of the consumer population of the facility is 65 years of age or older;

(3) none of the consumers are non-ambulatory;

(4) none of the consumers have a primary diagnosis of moderate, severe, or profound intellectual disability; and

(5) the facility must have been licensed under the Specialized Mental Health Rehabilitation Act or the Nursing Home Care Act immediately preceding July 22, 2013 (the effective date of this Act) and qualifies as an institute for mental disease under the federal definition of the term.

"Facility" does not include the following:

(1) a home, institution, or place operated by the federal government or agency thereof, or by the State of Illinois;

(2) a hospital, sanitarium, or other institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation as organized facilities therefor which is required to be licensed under the Hospital Licensing Act;

(3) a facility for child care as defined in the Child Care Act of 1969;

(4) a community living facility as defined in the Community Living Facilities Licensing Act;

(5) a nursing home or <u>sanitarium</u> ~~sanatorium~~ operated

solely by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any well-recognized church or religious denomination; however, such nursing home or sanitarium ~~sanatorium~~ shall comply with all local laws and rules relating to sanitation and safety;

(6) a facility licensed by the Department of Human Services as a community-integrated living arrangement as defined in the Community-Integrated Living Arrangements Licensure and Certification Act;

(7) a supportive residence licensed under the Supportive Residences Licensing Act;

(8) a supportive living facility in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code, except only for purposes of the employment of persons in accordance with Section 3-206.01 of the Nursing Home Care Act;

(9) an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act, except only for purposes of the employment of persons in accordance with Section 3-206.01 of the Nursing Home Care Act;

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

(11) a home, institution, or other place operated by

or under the authority of the Illinois Department of Veterans' Affairs;

(12) a facility licensed under the ID/DD Community Care Act;

(13) a facility licensed under the Nursing Home Care Act after July 22, 2013 (the effective date of this Act); or

(14) a facility licensed under the MC/DD Act.

"Executive director" means a person who is charged with the general administration and supervision of a facility licensed under this Act and who is a licensed nursing home administrator, licensed practitioner of the healing arts, or qualified mental health professional.

"Guardian" means a person appointed as a guardian of the person or guardian of the estate, or both, of a consumer under the Probate Act of 1975.

"Identified offender" means a person who meets any of the following criteria:

(1) Has been convicted of, found guilty of, adjudicated delinquent for, found not guilty by reason of insanity for, or found unfit to stand trial for, any felony offense listed in Section 25 of the Health Care Worker Background Check Act, except for the following:

(i) a felony offense described in Section 10-5 of the Nurse Practice Act;

(ii) a felony offense described in Section 4, 5,

6, 8, or 17.02 of the Illinois Credit Card and Debit Card Act;

(iii) a felony offense described in Section 5, 5.1, 5.2, 7, or 9 of the Cannabis Control Act;

(iv) a felony offense described in Section 401, 401.1, 404, 405, 405.1, 407, or 407.1 of the Illinois Controlled Substances Act; and

(v) a felony offense described in the Methamphetamine Control and Community Protection Act.

(2) Has been convicted of, adjudicated delinquent for, found not guilty by reason of insanity for, or found unfit to stand trial for~~,~~ any sex offense as defined in subsection (c) of Section 10 of the Sex Offender Management Board Act.

"Transitional living units" are residential units within a facility that have the purpose of assisting the consumer in developing and reinforcing the necessary skills to live independently outside of the facility. The duration of stay in such a setting shall not exceed 120 days for each consumer. Nothing in this definition shall be construed to be a prerequisite for transitioning out of a facility.

"Licensee" means the person, persons, firm, partnership, association, organization, company, corporation, or business trust to which a license has been issued.

"Misappropriation of a consumer's property" means the deliberate misplacement, exploitation, or wrongful temporary

or permanent use of a consumer's belongings or money without the consent of a consumer or his or her guardian.

"Neglect" means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance that is necessary to avoid physical harm and mental anguish of a consumer.

"Personal care" means assistance with meals, dressing, movement, bathing, or other personal needs, maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his or her person, whether or not a guardian has been appointed for such individual. "Personal care" shall not be construed to confine or otherwise constrain a facility's pursuit to develop the skills and abilities of a consumer to become self-sufficient and capable of increasing levels of independent functioning.

"Recovery and rehabilitation supports" means a program that facilitates a consumer's longer-term symptom management and stabilization while preparing the consumer for transitional living units by improving living skills and community socialization. The duration of stay in such a setting shall be established by the Department by rule.

"Restraint" means:

(i) a physical restraint that is any manual method or

physical or mechanical device, material, or equipment attached or adjacent to a consumer's body that the consumer cannot remove easily and restricts freedom of movement or normal access to one's body; devices used for positioning, including, but not limited to, bed rails, gait belts, and cushions, shall not be considered to be restraints for purposes of this Section; or

(ii) a chemical restraint that is any drug used for discipline or convenience and not required to treat medical symptoms; the Department shall, by rule, designate certain devices as restraints, including at least all those devices that have been determined to be restraints by the United States Department of Health and Human Services in interpretive guidelines issued for the purposes of administering Titles XVIII and XIX of the federal Social Security Act. For the purposes of this Act, restraint shall be administered only after utilizing a coercive free environment and culture.

"Self-administration of medication" means consumers shall be responsible for the control, management, and use of their own medication.

"Crisis stabilization" means a secure and separate unit that provides short-term behavioral, emotional, or psychiatric crisis stabilization as an alternative to hospitalization or re-hospitalization for consumers from residential or community placement. The duration of stay in such a setting shall not

exceed 21 days for each consumer.

"Therapeutic separation" means the removal of a consumer from the milieu to a room or area which is designed to aid in the emotional or psychiatric stabilization of that consumer.

"Triage center" means a non-residential 23-hour center that serves as an alternative to emergency room care, hospitalization, or re-hospitalization for consumers in need of short-term crisis stabilization. Consumers may access a triage center from a number of referral sources, including family, emergency rooms, hospitals, community behavioral health providers, federally qualified health providers, or schools, including colleges or universities. A triage center may be located in a building separate from the licensed location of a facility, but shall not be more than 1,000 feet from the licensed location of the facility and must meet all of the facility standards applicable to the licensed location. If the triage center does operate in a separate building, safety personnel shall be provided, on site, 24 hours per day and the triage center shall meet all other staffing requirements without counting any staff employed in the main facility building.

(Source: P.A. 102-1053, eff. 6-10-22; revised 8-24-22.)

Section 20. The Hospital Licensing Act is amended by changing Section 3 as follows:

(210 ILCS 85/3)

Sec. 3. As used in this Act:

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

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

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

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

(c) on and after January 1, 2023, a rural emergency hospital, as that term is defined under subsection (kkk)(2) of Section 1861 of the federal Social Security Act; to provide for the expeditious and timely implementation of this amendatory Act of the 102nd General Assembly, emergency rules to implement the changes made to

the definition of "hospital" by this amendatory Act of the 102nd General Assembly may be adopted by the Department subject to the provisions of Section 5-45 of the Illinois Administrative Procedure Act.

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

The term "hospital" does not include:

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

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

(3) hospitalization or care facilities maintained by the federal government or agencies thereof;

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

(5) any person or facility required to be licensed

pursuant to the Substance Use Disorder Act;

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

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

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

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

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

(D) "Director" means the Director of Public Health of the State of Illinois.

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

(F) "Federally designated organ procurement agency" means the organ procurement agency designated by the Secretary of

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

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

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

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

Section 25. The Behavior Analyst Licensing Act is amended by changing Sections 30, 35, and 150 as follows:

(225 ILCS 6/30)

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

Sec. 30. Qualifications for behavior analyst license.

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

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

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

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

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

(5) has paid the required fees.

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

the following:

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

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

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

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

(5) has paid the required fees.

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

(d) Each applicant for licensure as a ~~an~~ behavior analyst shall have his or her fingerprints submitted to the Illinois State Police in an electronic format that complies with the form and manner for requesting and furnishing criminal history record information as prescribed by the Illinois State Police. These fingerprints shall be transmitted through a live scan fingerprint vendor licensed by the Department. These fingerprints shall be checked against the Illinois State Police and Federal Bureau of Investigation criminal history

record databases now and hereafter filed, including, but not limited to, civil, criminal, and latent fingerprint databases. The Illinois State Police shall charge a fee for conducting the criminal history records check, which shall be deposited in the State Police Services Fund and shall not exceed the actual cost of the records check. The Illinois State Police shall furnish, pursuant to positive identification, records of Illinois convictions as prescribed under the Illinois Uniform Conviction Information Act and shall forward the national criminal history record information to the Department.

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

(225 ILCS 6/35)

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

Sec. 35. Qualifications for assistant behavior analyst license.

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

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

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

(3) has met the supervised work experience;

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

(5) has paid the required fees.

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

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

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

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

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

(5) has paid the required fees.

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

(d) Each applicant for licensure as an assistant behavior

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

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

(225 ILCS 6/150)

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

Sec. 150. License restrictions and limitations. Notwithstanding the exclusion in paragraph (2) of subsection (c) of Section 20 that permits an individual to implement a

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

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

Section 30. The Podiatric Medical Practice Act of 1987 is amended by adding Section 18.1 as follows:

(225 ILCS 100/18.1 new)

Sec. 18.1. Fee waivers. Notwithstanding any provision of

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

Section 35. The Illinois Public Aid Code is amended by changing Sections 5-5.2, 5-5.7b, and 5B-2 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) (Blank).

(c-1) Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a new reimbursement system based on the Patient Driven Payment Model (PDPM) has been fully operationalized, which shall take effect

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

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

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

(2) Costs shall be annually rebased and case mix index quarterly updated. The nursing services methodology will be assigned to the Medicaid enrolled residents on record as of 30 days prior to the beginning of the rate period in

the Department's Medicaid Management Information System (MMIS) as present on the last day of the second quarter preceding the rate period based upon the Assessment Reference Date of the Minimum Data Set (MDS).

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

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

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

(6) The Department shall establish a variable per diem staffing add-on in accordance with the most recent available federal staffing report, currently the Payroll Based Journal, for the same period of time, and if applicable adjusted for acuity using the same quarter's MDS. The Department shall rely on Payroll Based Journals provided to the Department of Public Health to make a determination of non-submission. If the Department is notified by a facility of missing or inaccurate Payroll Based Journal data or an incorrect calculation of

staffing, the Department must make a correction as soon as the error is verified for the applicable quarter.

Facilities with at least 70% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $9, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem of $14.88. Facilities with at least 80% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $14.88, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $23.80. Facilities with at least 92% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $23.80, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $29.75. Facilities with at least 100% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $29.75, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $35.70. Facilities with at least 110% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $35.70, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $38.68. Facilities with at least 125% or higher of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $38.68. Beginning April 1, 2023, no nursing facility's variable

staffing per diem add-on shall be reduced by more than 5% in 2 consecutive quarters. For the quarters beginning July 1, 2022 and October 1, 2022, no facility's variable per diem staffing add-on shall be calculated at a rate lower than 85% of the staffing indicated by the STRIVE study. No facility below 70% of the staffing indicated by the STRIVE study shall receive a variable per diem staffing add-on after December 31, 2022.

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

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

(B) for the quarter beginning October 1, 2022, the sum of the RUG-IV nursing component per diem multiplied by 0.80 and the PDPM nursing component per diem multiplied by 0.20;

(C) for the quarter beginning January 1, 2023, the sum of the RUG-IV nursing component per diem

multiplied by 0.60 and the PDPM nursing component per diem multiplied by 0.40;

(D) for the quarter beginning April 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.40 and the PDPM nursing component per diem multiplied by 0.60;

(E) for the quarter beginning July 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.20 and the PDPM nursing component per diem multiplied by 0.80; or

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

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

(1) Base rate spending pool shall be:

(A) The base year resident days which are calculated by multiplying the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) by 365.

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

(C) Thirteen million is added to the product of subparagraph (A) and subparagraph (B) to adjust for

the exclusion of nursing homes defined in paragraph (5).

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

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

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

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

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

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

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

(B) on and after July 1, 2014 and until July 1,

2022, shall be the amount calculated under subparagraph (A) of this paragraph (3) plus $1.76; and

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

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

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

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

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

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

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014 and

ending September 30, 2023, the RUG-IV nursing component per diem for a nursing home shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index, and the regional wage adjustor. For dates of service beginning July 1, 2022 and ending September 30, 2023, the Medicaid access adjustment described in subsection (e-3) shall be added to the product.

(e-3) A Medicaid Access Adjustment of $4 adjusted for the facility average PDPM case mix index calculated quarterly shall be added to the statewide PDPM nursing per diem for all facilities with annual Medicaid bed days of at least 70% of all occupied bed days adjusted quarterly. For each new calendar year and for the 6-month period beginning July 1, 2022, the percentage of a facility's occupied bed days comprised of Medicaid bed days shall be determined by the Department quarterly. For dates of service beginning January 1, 2023, the Medicaid Access Adjustment shall be increased to $4.75. This subsection shall be inoperative on and after January 1, 2028.

(f) (Blank).

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

(1) (Blank);

(2) (Blank);

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

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

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

(j) Notwithstanding any other provision of law, subject to federal approval, effective July 1, 2019, sufficient funds shall be allocated for changes to rates for facilities licensed under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities for dates of services on and after July 1, 2019: (i) to establish, through June 30, 2022 a per diem add-on to the direct care per diem rate not to exceed $70,000,000 annually in the aggregate taking into account federal matching funds for the purpose of addressing the facility's unique staffing needs, adjusted

quarterly and distributed by a weighted formula based on Medicaid bed days on the last day of the second quarter preceding the quarter for which the rate is being adjusted. Beginning July 1, 2022, the annual $70,000,000 described in the preceding sentence shall be dedicated to the variable per diem add-on for staffing under paragraph (6) of subsection (d); and (ii) in an amount not to exceed $170,000,000 annually in the aggregate taking into account federal matching funds to permit the support component of the nursing facility rate to be updated as follows:

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

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

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

(k) During the first quarter of State Fiscal Year 2020,

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

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

(1) Incentive payments determined by facility performance on specified quality measures in an initial amount of $70,000,000. Nothing in this subsection shall be construed to limit the quality of care payments in the aggregate statewide to $70,000,000, and, if quality of care has improved across nursing facilities, the Department shall adjust those add-on payments accordingly. The quality payment methodology described in this subsection must be used for at least State Fiscal Year

2023. Beginning with the quarter starting July 1, 2023, the Department may add, remove, or change quality metrics and make associated changes to the quality payment methodology as outlined in subparagraph (E). Facilities designated by the Centers for Medicare and Medicaid Services as a special focus facility or a hospital-based nursing home do not qualify for quality payments.

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

(B) Star rating weights are assigned based on the nursing home's star rating for the LTS quality star rating. As used in this subparagraph, "LTS quality star rating" means the long-term stay quality rating for each nursing facility, as assigned by the Centers for Medicare and Medicaid Services under the Five-Star Quality Rating System. The rating is a number ranging from 0 (lowest) to 5 (highest).

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

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

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

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

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

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

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

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

to the methodology for distributing quality pool payments.

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

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

(2) Payments based on CNA tenure, promotion, and CNA training for the purpose of increasing CNA compensation. It is the intent of this subsection that payments made in accordance with this paragraph be directly incorporated into increased compensation for CNAs. As used in this paragraph, "CNA" means a certified nursing assistant as that term is described in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, and Section 3-206 of the MC/DD Act. The Department shall establish, by rule, payments to nursing facilities equal to Medicaid's share of the tenure wage increments specified in this paragraph for all reported CNA employee hours compensated according to a posted schedule consisting of increments at least as large as those specified in this paragraph. The increments are as

follows: an additional $1.50 per hour for CNAs with at least one and less than 2 years' experience plus another $1 per hour for each additional year of experience up to a maximum of $6.50 for CNAs with at least 6 years of experience. For purposes of this paragraph, Medicaid's share shall be the ratio determined by paid Medicaid bed days divided by total bed days for the applicable time period used in the calculation. In addition, and additive to any tenure increments paid as specified in this paragraph, the Department shall establish, by rule, payments supporting Medicaid's share of the promotion-based wage increments for CNA employee hours compensated for that promotion with at least a $1.50 hourly increase. Medicaid's share shall be established as it is for the tenure increments described in this paragraph. Qualifying promotions shall be defined by the Department in rules for an expected 10-15% subset of CNAs assigned intermediate, specialized, or added roles such as CNA trainers, CNA scheduling "captains", and CNA specialists for resident conditions like dementia or memory care or behavioral health.

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

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

(305 ILCS 5/5-5.7b)

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

(a) Definitions. As used in this Section:

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

"Qualifying Ground Ambulance Service Provider" means a "vehicle service provider," as that term is defined in Section 3.85 of the Emergency Medical Services (EMS) Systems Act, which operates licensed ambulances for the purpose of providing emergency, non-emergency ambulance services, or both emergency and non-emergency ambulance services. The term "Qualifying Ground Ambulance Service Provider" is limited to ambulance and EMS agencies that are privately held and nonprofit organizations headquartered within the State and licensed by the Department of Public Health as of March 12, 2020.

"Eligible worker" means a staff member of a Qualifying Ground Ambulance Service Provider engaged in "essential work", as defined by Section 9901 of the ARPA and related federal guidance, and (1) whose total pay is below 150% of the average

annual wage for all occupations in the worker's county of residence, as defined by the BLS Occupational Employment and Wage Statistics or (2) is not exempt from the federal Fair Labor Standards Act overtime provisions.

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

(b-1) By December 31, 2022, the Department shall obtain appropriate documentation from Qualifying Ground Ambulance Service Providers to ascertain an accurate count of the number of licensed vehicles available to serve enrollees in the State's medical assistance programs, which shall be known as the "total eligible vehicles". By February 28, 2023, Qualifying Ground Ambulance Service Providers shall be

initially notified of their eligible award, which shall be the product of (i) the total amount of funds allocated under this Section and (ii) a quotient, the numerator of which is the number of licensed ground ambulance vehicles of an individual Qualifying Ground Ambulance Service Provider and the denominator of which is the total eligible vehicles. After March 31, 2024, any unobligated funds shall be reallocated pro rata to the remaining Qualifying Ground Ambulance Service Providers that are able to prove up eligible expenses in excess of their initial award amount until all such appropriated funds are exhausted.

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

(c) Non-Emergency Service Certification. To be eligible for funding under this Section, a Qualifying Ground Ambulance Service Provider that provides non-emergency services to institutional residents must certify whether or not it is able to ~~that it will~~ provide non-emergency ambulance services to individuals enrolled in the State's Medical Assistance Program and residing in non-institutional settings for at least one year following the receipt of funding pursuant to this amendatory Act of the 102nd General Assembly. Certification indicating that a provider has such an ability does not mean that a provider is required to accept any or all requested

transports. ~~The provider shall maintain the certification in its records. The provider shall also maintain documentation of all non-emergency ambulance services for the period covered by the certification. The provider shall produce the certification and supporting documentation upon demand by the Department or its representative. Failure to comply shall result in recovery of any payments made by the Department.~~

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

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

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

(3) Upon receipt of funds, the Qualifying Ground Ambulance Service Provider shall distribute funds such that an eligible worker receives an amount up to $13 per

hour but no more than $25,000 for the duration of the program. The Qualifying Ground Ambulance Service Provider shall provide a written certification to the Department acknowledging compliance with this paragraph (d).

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

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

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

(e) COVID-19 Response Support Initiative. Subject to paragraph (c) of this Section and based on an application filed by a Qualifying Ground Ambulance Service Provider, the Department shall establish the Ground Ambulance COVID-19 Response Support Initiative. The purpose of the award shall be to reimburse Qualifying Ground Ambulance Service Providers for eligible expenses under Section 9901 of the ARPA related to the public health impacts of the COVID-19 public health emergency, including, but not limited to: (i) costs incurred due to the COVID-19 public health emergency; (ii) costs related to vaccination programs, including vaccine incentives; (iii) costs related to COVID-19 testing; (iv) costs related to

COVID-19 prevention and treatment equipment; (v) expenses for medical supplies; (vi) expenses for personal protective equipment; (vii) costs related to isolation and quarantine; (viii) costs for ventilation system installation and improvement; (ix) costs related to other emergency response equipment, such as ground ambulances, ventilators, cardiac monitoring equipment, defibrillation equipment, pacing equipment, ambulance stretchers, and radio equipment; and (x) other emergency medical response expenses. ~~costs related to COVID-19 testing for patients, COVID-19 prevention and treatment equipment, medical supplies, personal protective equipment, and other emergency medical response treatments.~~

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

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

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

addressed by the expenditures and how that capital expenditure is appropriate to address that identified harm or need.

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

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

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

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

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

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

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

(a) For the privilege of engaging in the occupation of long-term care provider, beginning July 1, 2011 through June

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

(a-1) For the privilege of engaging in the occupation of long-term care provider for each occupied non-Medicare bed day, beginning July 1, 2022, an assessment is imposed upon each long-term care provider in an amount varying with the number of paid Medicaid resident days per annum in the facility with the following schedule of occupied bed tax amounts. This assessment is due and payable each month. The tax shall follow the schedule below and be rebased by the Department on an annual basis. The Department shall publish each facility's rebased tax rate according to the schedule in this Section 30 days prior to the beginning of the 6-month period beginning July 1, 2022 and thereafter 30 days prior to the beginning of each calendar year which shall incorporate the number of paid Medicaid days used to determine each facility's rebased tax rate.

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

$10.67.

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

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

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

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

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

(7) Any non-profit nursing facilities without Medicaid-certified beds or any nursing facility owned and operated by a county government, $7 per occupied bed day. The changes made by this amendatory Act of the 102nd General Assembly to this paragraph (7) shall be implemented only upon federal approval.

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

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

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

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

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

Section 40. The Rebuild Illinois Mental Health Workforce Act is amended by changing Sections 20-10 and 20-20 as follows:

(305 ILCS 66/20-10)

Sec. 20-10. Medicaid funding for community mental health

services. Medicaid funding for the specific community mental health services listed in this Act shall be adjusted and paid as set forth in this Act. Such payments shall be paid in addition to the base Medicaid reimbursement rate and add-on payment rates per service unit.

(a) The payment adjustments shall begin on July 1, 2022 for State Fiscal Year 2023 and shall continue for every State fiscal year thereafter.

(1) Individual Therapy Medicaid Payment rate for services provided under the H0004 Code:

(A) The Medicaid total payment rate for individual therapy provided by a qualified mental health professional shall be increased by no less than $9 per service unit.

(B) The Medicaid total payment rate for individual therapy provided by a mental health professional shall be increased by no less then $9 per service unit.

(2) Community Support - Individual Medicaid Payment rate for services provided under the H2015 Code: All community support - individual services shall be increased by no less than $15 per service unit.

(3) Case Management Medicaid Add-on Payment for services provided under the T1016 code: All case management services rates shall be increased by no less than $15 per service unit.

(4) Assertive Community Treatment Medicaid Add-on

Payment for services provided under the H0039 code: The Medicaid total payment rate for assertive community treatment services shall increase by no less than $8 per service unit.

(5) Medicaid user-based directed payments.

(A) For each State fiscal year, a monthly directed payment shall be paid to a community mental health provider of community support team services based on the number of Medicaid users of community support team services documented by Medicaid fee-for-service and managed care encounter claims delivered by that provider in the base year. The Department of Healthcare and Family Services shall make the monthly directed payment to each provider entitled to directed payments under this Act by no later than the last day of each month throughout each State fiscal year.

(i) The monthly directed payment for a community support team provider shall be calculated as follows: The sum total number of individual Medicaid users of community support team services delivered by that provider throughout the base year, multiplied by $4,200 per Medicaid user, divided into 12 equal monthly payments for the State fiscal year.

(ii) As used in this subparagraph, "user" means an individual who received at least 200

units of community support team services (H2016) during the base year.

(B) For each State fiscal year, a monthly directed payment shall be paid to each community mental health provider of assertive community treatment services based on the number of Medicaid users of assertive community treatment services documented by Medicaid fee-for-service and managed care encounter claims delivered by the provider in the base year.

(i) The monthly direct payment for an assertive community treatment provider shall be calculated as follows: The sum total number of Medicaid users of assertive community treatment services provided by that provider throughout the base year, multiplied by $6,000 per Medicaid user, divided into 12 equal monthly payments for that State fiscal year.

(ii) As used in this subparagraph, "user" means an individual that received at least 300 units of assertive community treatment services during the base year.

(C) The base year for directed payments under this Section shall be calendar year 2019 for State Fiscal Year 2023 and State Fiscal Year 2024. For the State fiscal year beginning on July 1, 2024, and for every State fiscal year thereafter, the base year shall be

the calendar year that ended 18 months prior to the start of the State fiscal year in which payments are made.

(b) Subject to federal approval, a one-time directed payment must be made in calendar year 2023 for community mental health services provided by community mental health providers. The one-time directed payment shall be for an amount appropriated for these purposes. The one-time directed payment shall be for services for Integrated Assessment and Treatment Planning and other intensive services, including, but not limited to, services for Mobile Crisis Response, crisis intervention, and medication monitoring. The amounts and services used for designing and distributing these one-time directed payments shall not be construed to require any future rate or funding increases for the same or other mental health services.

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

(305 ILCS 66/20-20)

Sec. 20-20. Base Medicaid rates or add-on payments.

(a) For services under subsection (a) of Section 20-10. No base Medicaid rate or Medicaid rate add-on payment or any other payment for the provision of Medicaid community mental health services in place on July 1, 2021 shall be diminished or changed to make the reimbursement changes required by this Act. Any payments required under this Act that are delayed due

to implementation challenges or federal approval shall be made retroactive to July 1, 2022 for the full amount required by this Act ~~regardless of the amount a provider bills Illinois' Medical Assistance Program (via a Medicaid managed care organization or the Department of Healthcare and Family Services directly) for such services~~.

(b) For directed payments under subsection (b) of Section 20-10. No base Medicaid rate payment or any other payment for the provision of Medicaid community mental health services in place on January 1, 2023 shall be diminished or changed to make the reimbursement changes required by this Act. The Department of Healthcare and Family Services must pay the directed payment in one installment within 60 days of receiving federal approval.

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

Section 45. The Code of Criminal Procedure of 1963 is amended by changing Sections 104-17 and 104-23 as follows:

(725 ILCS 5/104-17) (from Ch. 38, par. 104-17)

Sec. 104-17. Commitment for treatment; treatment plan.

(a) If the defendant is eligible to be or has been released on pretrial release or on his own recognizance, the court shall select the least physically restrictive form of treatment therapeutically appropriate and consistent with the treatment plan. The placement may be ordered either on an

inpatient or an outpatient basis.

(b) If the defendant's disability is mental, the court may order him placed for secure treatment in the custody of the Department of Human Services, or the court may order him placed in the custody of any other appropriate public or private mental health facility or treatment program which has agreed to provide treatment to the defendant. If the most serious charge faced by the defendant is a misdemeanor, the court shall order outpatient treatment, unless the court finds good cause on the record to order inpatient treatment. If the court orders the defendant to inpatient treatment ~~placed~~ in the custody of the Department of Human Services, the Department shall evaluate the defendant to determine the most appropriate ~~to which~~ secure facility to receive the defendant ~~shall be transported~~ and, within 20 days of the transmittal by the clerk of the circuit court of the court's placement ~~court~~ order, notify the court of ~~sheriff of~~ the designated facility to receive the defendant. The Department shall admit the defendant to a secure facility within 60 days of the transmittal of the court's placement order, unless the Department can demonstrate good faith efforts at placement and a lack of bed and placement availability. If placement cannot be made within 60 days of the transmittal of the court's placement order and the Department has demonstrated good faith efforts at placement and a lack of bed and placement availability, the Department shall provide an update to the

ordering court every 30 days until the defendant is placed. Once bed and placement availability is determined, the Department shall notify ~~Upon receipt of that notice,~~ the sheriff who shall promptly transport the defendant to the designated facility. If the defendant is placed in the custody of the Department of Human Services, the defendant shall be placed in a secure setting. During the period of time required to determine bed and placement availability at the designated facility, ~~the appropriate placement~~ the defendant shall remain in jail. If during the course of evaluating the defendant for placement, the Department of Human Services determines that the defendant is currently fit to stand trial, it shall immediately notify the court and shall submit a written report within 7 days. In that circumstance the placement shall be held pending a court hearing on the Department's report. Otherwise, upon completion of the placement process, including identifying bed and placement availability, the sheriff shall be notified and shall transport the defendant to the designated facility. If, within 60 ~~20~~ days of the transmittal by the clerk of the circuit court of the court's placement ~~court~~ order, the Department fails to provide ~~notify~~ the sheriff with notice of bed and placement availability at the designated facility, ~~of the identity of the facility to which the defendant shall be transported,~~ the sheriff shall contact ~~a designated person within~~ the Department to inquire about when a placement will become available at the designated

facility as well as bed and placement ~~and bed~~ availability at other secure facilities. ~~If, within 20 days of the transmittal by the clerk of the circuit court of the placement court order, the Department fails to notify the sheriff of the identity of the facility to which the defendant shall be transported, the sheriff shall notify the Department of its intent to transfer the defendant to the nearest secure mental health facility operated by the Department and inquire as to the status of the placement evaluation and availability for admission to such facility operated by the Department by contacting a designated person within the Department.~~ The Department shall respond to the sheriff within 2 business days of the notice and inquiry by the sheriff seeking the transfer and the Department shall provide the sheriff with the status of the evaluation, information on bed and placement availability, and an estimated date of admission for the defendant and any changes to that estimated date of admission. If the Department notifies the sheriff during the 2 business day period of a facility operated by the Department with placement availability, the sheriff shall promptly transport the defendant to that facility. The placement may be ordered either on an inpatient or an outpatient basis.

(c) If the defendant's disability is physical, the court may order him placed under the supervision of the Department of Human Services which shall place and maintain the defendant in a suitable treatment facility or program, or the court may

order him placed in an appropriate public or private facility or treatment program which has agreed to provide treatment to the defendant. The placement may be ordered either on an inpatient or an outpatient basis.

(d) The clerk of the circuit court shall within 5 days of the entry of the order transmit to the Department, agency or institution, if any, to which the defendant is remanded for treatment, the following:

(1) a certified copy of the order to undergo treatment. Accompanying the certified copy of the order to undergo treatment shall be the complete copy of any report prepared under Section 104-15 of this Code or other report prepared by a forensic examiner for the court;

(2) the county and municipality in which the offense was committed;

(3) the county and municipality in which the arrest took place;

(4) a copy of the arrest report, criminal charges, arrest record; and

(5) all additional matters which the Court directs the clerk to transmit.

(e) Within 30 days of admission to the designated facility ~~entry of an order to undergo treatment~~, the person supervising the defendant's treatment shall file with the court, the State, and the defense a report assessing the facility's or program's capacity to provide appropriate treatment for the

defendant and indicating his opinion as to the probability of the defendant's attaining fitness within a period of time from the date of the finding of unfitness. For a defendant charged with a felony, the period of time shall be one year. For a defendant charged with a misdemeanor, the period of time shall be no longer than the sentence if convicted of the most serious offense. If the report indicates that there is a substantial probability that the defendant will attain fitness within the time period, the treatment supervisor shall also file a treatment plan which shall include:

(1) A diagnosis of the defendant's disability;

(2) A description of treatment goals with respect to rendering the defendant fit, a specification of the proposed treatment modalities, and an estimated timetable for attainment of the goals;

(3) An identification of the person in charge of supervising the defendant's treatment.

(Source: P.A. 100-27, eff. 1-1-18; 101-652, eff. 1-1-23.)

(725 ILCS 5/104-23) (from Ch. 38, par. 104-23)

Sec. 104-23. Unfit defendants. Cases involving an unfit defendant who demands a discharge hearing or a defendant who cannot become fit to stand trial and for whom no special provisions or assistance can compensate for his disability and render him fit shall proceed in the following manner:

(a) Upon a determination that there is not a substantial

probability that the defendant will attain fitness within the time period set in subsection (e) of Section 104-17 of this Code from the original finding of unfitness, the court shall hold a discharge hearing within 60 days, unless good cause is shown for the delay. ~~a defendant or the attorney for the defendant may move for a discharge hearing pursuant to the provisions of Section 104-25. The discharge hearing shall be held within 120 days of the filing of a motion for a discharge hearing, unless the delay is occasioned by the defendant.~~

(b) If at any time the court determines that there is not a substantial probability that the defendant will become fit to stand trial or to plead within the time period set in subsection (e) of Section 104-17 of this Code from the date of the original finding of unfitness, or if at the end of the time period set in subsection (e) of Section 104-17 of this Code from that date the court finds the defendant still unfit and for whom no special provisions or assistance can compensate for his disabilities and render him fit, the State shall request the court:

(1) To set the matter for hearing pursuant to Section 104-25 unless a hearing has already been held pursuant to paragraph (a) of this Section; or

(2) To release the defendant from custody and to dismiss with prejudice the charges against him; or

(3) To remand the defendant to the custody of the Department of Human Services and order a hearing to be

conducted pursuant to the provisions of the Mental Health and Developmental Disabilities Code, as now or hereafter amended. The Department of Human Services shall have 7 days from the date it receives the defendant to prepare and file the necessary petition and certificates that are required for commitment under the Mental Health and Developmental Disabilities Code. If the defendant is committed to the Department of Human Services pursuant to such hearing, the court having jurisdiction over the criminal matter shall dismiss the charges against the defendant, with the leave to reinstate. In such cases the Department of Human Services shall notify the court, the State's attorney and the defense attorney upon the discharge of the defendant. A former defendant so committed shall be treated in the same manner as any other civilly committed patient for all purposes including admission, selection of the place of treatment and the treatment modalities, entitlement to rights and privileges, transfer, and discharge. A defendant who is not committed shall be remanded to the court having jurisdiction of the criminal matter for disposition pursuant to subparagraph (1) or (2) of paragraph (b) of this Section.

(c) If the defendant is restored to fitness and the original charges against him are reinstated, the speedy trial provisions of Section 103-5 shall commence to run.

(Source: P.A. 98-1025, eff. 8-22-14.)

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