HB4443

LRB10224090KTG33314b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB4443

Introduced 1/21/2022, by Rep. Elizabeth Hernandez - LaToya Greenwood - Jay Hoffman - Jonathan Carroll - Daniel Didech, et al.

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5.2a new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Declares that all changes to the existing nursing facility direct care reimbursement rate methodologies and to the bed assessment and collection procedures must be approached with caution, executed deliberately, and held to the highest of standards in order to protect nursing facility residents from disruption in care, protect workers from lost wages and jobs, and protect providers from the increased instability within the industry. Provides that a Nursing Facility Oversight Committee (Committee) shall be named by the 4 legislative leaders to oversee, assess, and provide direction to the Department of Healthcare and Family Services as it relates to long term care services. Contains provisions on the Committee's composition, meetings, proxy voting, and other matters. Requires the Department to seek the advice and consent of the Committee prior to filing emergency or permanent administrative rules with the Secretary of State or submitting Medicaid State Plan amendments and all correspondence to the Centers for Medicare and Medicaid Services. Requires the Department to prepare transition plans for the redesign of the direct care reimbursement rate methodologies and the assessment tax schedule and collection proceedings. Contains provisions concerning advanced notice to nursing facilities of all payment, award, and rate changes; a quarterly direct care per diem reimbursement rate for each nursing facility; direct care reimbursement rate components subject to redesign; establishment of a single quarterly non-Medicare occupied bed varied tax assessment; State Plan amendments to permit expedited implementation of the redesigned bed assessment; compliance requirements for managed care organizations; penalties for non-compliance; and other matters. Effective immediately.

LRB102 24090 KTG 33314 b

A BILL FOR

AN ACT concerning public aid.

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

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

(305 ILCS 5/5-5.2a new)

Sec. 5-5.2a. Nursing facility direct care reimbursement rates and bed tax methodologies.

(a) This Section may be referred to as the Nursing Facilities Direct Care Reimbursement Rate and Bed Tax Redesign of 2022 Act.

The General Assembly declares that the following are in the best interest of the State:

(1) All changes to the existing nursing facility direct care reimbursement rate methodologies and to the bed assessment and collection procedures must be approached with caution, executed deliberately, and held to the highest of standards to protect nursing facility residents from disruption in care, protect workers from lost wages and jobs, and protect providers from the increased instability within the industry.

(2) All direct care reimbursements shall be paid on a per diem basis, except lump sum awards for staff years of

service and specialized training. Nothing shall preclude the State from providing additional funding to nursing facilities for direct care in a form other than a per diem rate in an emergency.

(3) The Department of Healthcare and Family Services shall represent the interests of the State and the managed care organizations in the redesign of the nursing facility direct care reimbursement rates and bed tax methodologies; as such, the managed care organizations shall be bound by the negotiated agreements of the Department.

(4) Managed care organizations under contract with the State must pay to each individual nursing facility no less than the Medicaid fee-for-service reimbursement rate established by the Department in accordance with this Section, and all subsequent modifications to the Medicaid reimbursement system, and in effect at the time the service is provided.

(5) Managed care organizations are expressly prohibited, at any time and for any reason, from offering, negotiating, or entering into contracts with a nursing facility for a level of compensation less than the Medicaid fee-for-service rate in effect at the time the service is rendered.

(b) Nursing Facility Oversight Committee.

(1) A Nursing Facility Oversight Committee shall be named by the 4 legislative leaders to oversee, assess, and

provide direction to the Department as it relates to long term care services, including, but not limited to, Medicaid reimbursement, bed assessments, managed long term care, and Medicaid and long term care eligibility. The Committee shall be expressly charged with overseeing, assessing, and providing leadership to the Department on the execution of this Section and with the ongoing evaluation of the effectiveness of any and all provisions.

(2) The Committee shall be comprised of 12 voting members with each legislative leader appointing 2 legislative members and a member of the general public recommended by membership-based nursing home trade associations. Each legislative leader shall identify one legislative member to serve as a co-chair. Members shall serve until a replacement is named. Citizen members shall serve without compensation.

(3) The co-chairs shall call the first meeting within 30 days after the effective date of this amendatory Act of the 102nd General Assembly, but no later than 10 business days prior to the Department's initial submission of State Plan amendments in accordance with this Section.

(4) The Department shall provide copies of all documents at least 10 days in advance of a meeting at which the Department is asking the Committee to give comment or approval.

(5) The Committee shall meet at least monthly during

the implementation of redesigns, quarterly thereafter, and more frequently at the call of the co-chairs.

(6) Voting members unable to attend a meeting may submit comments in writing prior to the meeting. Voting members may attend and vote in person, by phone or by teleconference, or may name a proxy to attend and vote in their place. Proxies shall be named in writing, which may be submitted by the appointee or by the legislative leader who appointed them, and delivered to each of the co-chairs.

(7) The Committee shall hold at least 2 open forums, one in Chicago and one in Springfield, to accept comments on implementation of this Section, to host the Department to respond to questions concerning its implementation plans, and to encourage members of the public, family members of nursing home residents, and licensed operators to share their issues and concerns.

(8) Prior to filing emergency or permanent administrative rules with the Secretary of State or submitting Medicaid State Plan amendments and all substantive correspondence with the Centers for Medicare and Medicaid Services, the Department shall seek the advice and consent of the Committee. The Department shall provide the Committee members with no fewer than 10 business days to review materials and seek additional information prior to requesting the members' advice and

consent. The Department shall designate a person to answer questions and accept comments in advance of the meeting, at which time a vote shall occur.

(c) Direct care rate methodologies and assessment schedules and collection procedures.

(1) As used in this Section:

"Direct care" means the direct care component of the Medicaid reimbursement rate paid to nursing facilities.

"Direct care reimbursement" means compensation for direct care paid by the Department or a managed care company to a Medicaid certified nursing facility.

"Nursing facility" means a nursing home that is licensed under the Nursing Home Care Act.

"Per diem add-ons" means additional direct care compensation paid to a nursing facility meeting the standards or benchmarks as specified in this Section as part of its daily Medicaid rate.

"PDPM" means the Patient Driven Payment Model developed by the federal Centers for Medicare and Medicaid Services.

"RUG" means the Resource Utilization Group system for grouping a nursing facility's residents according to their clinical and functional status identified in Minimum Data Set data supplied by a facility.

(2) The Department shall prepare a transition plan for the redesign of the direct care reimbursement rate

methodologies and a transition plan for the redesign of assessment tax schedule and collection procedures, which shall include projected implementation dates. The plan shall be submitted to the Nursing Facility Oversight Committee for its review, comment, and approval; posted on the Department's website; and provided to the public by the Department upon request.

(3) Individual nursing facilities shall be notified by the Department of any and all changes prior to their taking effect that impact payments, awards, or rates paid to or paid by individual nursing facilities, including, but not be limited to, direct care reimbursement rates methodologies, taxes and assessments, rate add-ons and adjustments, levels of staffing compliance, directed payments, incentive payments, lump sum awards, case mix indices, census, and bed days.

(4) No less than 60 days' notice shall be given by the Department to nursing facilities before any modifications to any portion of the reimbursement methodologies and bed assessment tax schedule and collection procedures become effective.

(5) No less than 30 days' notice shall be given by the Department to nursing facilities before any rebasing, rate adjustments, bed tax adjustment, or Medicaid bed days become effective.

(6) Notices shall include sufficient information to

permit the nursing facilities to challenge the accuracy of the data, the validity of the formulas used, or the specific calculations. The notice shall include instructions on how to file an appeal.

(d) Direct care reimbursement rate redesign.

(1) Direct care reimbursement methodologies in place on the effective date of this amendatory Act of the 102nd General Assembly and identified for phase-out or modification shall remain in place in whole or in part until the replacement methodologies are fully operational to ensure continuity and to provide a safety net necessary to achieve the General Assembly's declaration.

(2) The Department shall establish a direct care per diem reimbursement rate on a quarterly basis for each nursing facility. The direct care per diem reimbursement rate shall be inclusive of all compensation paid by the State for the direct care whether determined by formula, add-ons or adjustments, awards, or any other type of compensation. Only funding for years of service and specialized training shall be paid to nursing facilities in a lump sum. Nothing precludes the State from providing additional funding to nursing facilities for direct care in a form other than a per diem rate in an emergency.

(3) Authorization for the direct care reimbursement rate redesign provided in this Section shall be dependent on securing an additional $60,000,000 in General Revenue

funding for State Fiscal Year 2023. Failure of the General Assembly to appropriate the additional funds shall result in the repeal of the authorization, require modification of the redesign, and necessitate reauthorization by the General Assembly. The Department shall work with the Nursing Facility Oversight Committee and membership-based nursing home trade associations to develop a redesign consistent with the available funding.

(4) Direct care reimbursement rate components subject to the redesign shall include all of the following:

(A) A case mix protocol.

(B) A regional wage adjuster per diem add-on.

(C) A direct care base per diem rate.

(D) A staffing per diem add-on.

(E) A special care needs per diem add-on.

(F) A Medicaid access per diem add-on.

(G) A quality incentive performance measure per diem add-on.

(H) Quality incentive lump sum awards.

(e) Case mix protocol. The current RUGs-based case mix protocol shall remain operational until replaced by a fully operational PDPM-based case mix protocol, which shall be resident-centered, facility-specific, and cost-based. Costs shall be annually rebased and the case mix index quarterly updated.

(1) PDPM nursing case mix indices shall be applied to

all resident classes at no less than 79% of the Centers for Medicare and Medicaid Services' PDPM unadjusted case mix values utilizing an index maximization approach. No resident class shall be held at the level applicable to the RUG-IV model in effect prior to January 1, 2022.

(2) The per diem rate shall be based on Medicaid-qualified residents on record as of 30 days prior to the beginning of the rate period in the Department's Medicaid Management Information System, or its successor, as present in the nursing facility on the last day of the second quarter preceding the rate period based upon the Assessment Reference Date of the Minimum Data Set (MDS). Case mix indices and PDPM unadjusted case mix values used shall be for the same period of time.

(3) A 24-month hold harmless period shall begin with the first month the PDPM is fully operational. During the hold harmless period, the Department shall pay each nursing facility based on its PDPM-based score or its RUGS-based score, whichever is greater.

(f) Regional wage adjustor. The regional wage adjustors, as provided in paragraph (3) of subsection (d) of Section 5-5.2, in effect January 1, 2022 shall remain in effect.

(g) Direct care base per diem rate. $5 shall be added to the base per diem rate produced by the cost-based formula contained in paragraph (5) of subsection (d) of Section 5-5.2 in effect on January 1, 2022.

(h) Variable staff per diem add-on.

(1) The direct care staffing add-on shall be replaced by the variable staffing per diem add-on, which shall be based on compliance with the Centers for Medicare and Medicaid Services' RUGs-based staff time measurement STRIVE study and rebased quarterly using the Payroll Based Journal report for the same period of time adjusted for psychiatric services rehabilitation directors, psychiatric services rehab coordinators, and psychiatric services rehab aides employed by facilities described in 77 Ill. Adm. Code 300.Subpart S and for acuity. Until the Centers for Medicare and Medicaid Services releases a PDPM staff time measurement study and its use for determining staffing compliance is approved by the General Assembly, the Department shall maintain the RUGs-based case mix system for the purpose of determining compliance with the STRIVE-based staffing requirements.

(2) No nursing facility's variable staffing per diem add-on shall be reduced by more than 5% in 2 consecutive quarters.

(3) Variable staffing per diem add-ons shall be adjusted for each whole percentage point:

(A) $6 for under 70% compliance.

(B) $9 for 70% compliance and adjusted incrementally for each whole percentage point up to and including 79% compliance.

(C) $14.88 for 80% compliance and adjusted incrementally for each whole percentage point up to and including 91% compliance.

(D) $23.80 for 92% compliance and adjusted incrementally for each whole percentage point up to and including 99% compliance.

(E) $29.75 for 100% compliance and adjusted incrementally for each whole percentage point up to and including 109% compliance.

(F) $35.70 for 110% compliance and adjusted incrementally for each whole percentage point up to and including 124% compliance.

(G) $38.68 for 125% and above compliance.

(i) Special care needs per diem add-on. A special care needs per diem add-on shall be applicable for the following residents:

(1) Alzheimer and other dementia diseases add-on of $0.89 for residents scoring in I4200 or I4800 on the MDS.

(2) Mental health add-on of $2.67 for residents who scores either a "1" or "2" in any items S1200A through S1200I and also scores in a RUGs group PA1, PA2, BA1, or BA2.

(j) Medicaid access per diem add-on. Nursing facilities with annual Medicaid bed days between 5,001 to 55,000, which comprise at least 70% of all annual occupied bed days for the same period of time, shall receive a $6 Medicaid access per

diem add-on, which shall be rebased quarterly.

(k) Quality incentive per diem add-ons.

(1) Performance measure per diem add-on. Nursing facilities shall receive a performance measure per diem add-on, which shall be adjusted quarterly based on the Centers for Medicare and Medicaid Services actual quality star ratings for long term stays contained in the Five-Star Quality Ratings System for the quarter in which the per diem is calculated based on the add-on schedule below:

Five-Star Long Stay Quality Rating	Performance Measure Per Diem Add-on
5 Stars	$9.66
4 Stars	$6.90
3 Stars	$4.14
2 Stars	$2.07
1 Star	$0

In the first year, the Department shall at the end of the third quarter proportionately adjust the add-on schedule for fourth quarter awards to ensure that no less than $70,000,000 and no more than $70,000,000 is awarded in the aggregate for the entire year. The Department shall recalibrate the table above to reflect the actual dollar values for an entire 12-month period and request the assistance of the Nursing Facility Oversight Committee to correct the table in statute.

In the second and subsequent years, the Department shall apply the per diem add-on schedule in statute, and no change to the table shall be requested or made that would limit the growth of the performance measure per diem add-on in the aggregate.

(2) Years of services and specialized training lump sum awards.

(A) Years of service lump sum award. Nursing facilities shall receive quarterly lump sum awards based on staff years of service data contained in the Payroll Based Journal. The incentive calculation shall be based on hours of service and shall range from $1.50 per hour of service for workers with the equivalent of more than one year and less than 2 years of service to $6.50 per hour of service for workers with the equivalent of 6 or more years of service.

(B) Specialized training lump sum award. The Department shall assist nursing facilities in providing specialized training for qualified staff. Cost sharing awards shall be based on annual reports filed with the Department detailing specific costs and employees participating in the training program and the facility's percentage of Medicaid bed days. In the first year the State's share shall be no greater than 50% of the cost of the training attributed to Medicaid bed days with the State's share growing to 80% over 5

years.

(l) Bed assessment redesign. The existing non-Medicare occupied bed flat tax assessment and the licensed bed fee shall remain operational until a replacement is approved by the Centers for Medicare and Medicaid Services and is fully operational. Both levies shall be replaced by a single quarterly non-Medicare occupied bed varied tax assessment. The tax schedule shall be based on Medicaid bed days and levied against all non-Medicare occupied beds. One-fourth of the annual Medicaid bed days in the table below shall be attributed to each quarter for the purposes of determining an individual facility's tax for a specific quarter. The tax schedule as it appears below shall remain in effect until it is modified by the General Assembly.

Annual Medicaid Bed Days	Tax
No certified Medicaid beds	$7
1-5,000	$10.67
5,001-15,000	$19.20
15,001-35,000	$22.40
35,001-55,000	$19.20
55,001-65,000	$13.86
greater than 65,000	$10.67

(1) To expedite collection and distribution of the enhanced revenue generated by the bed assessment redesign, the Department shall submit to the Centers for Medicare and Medicaid Services a State Plan amendment providing for

an immediate start date for the collection of the enhanced assessment and distribution using the existing direct care reimbursement methodology with a gradual phase-in of the reimbursement rate redesign.

(2) In the first year, it is assumed the new assessment, which shall be calculated and paid on a quarterly basis, will generate an amount approximately equal to 6% of revenues annually. All funds generated by the bed assessment redesign shall be used exclusively to increase the funding for nursing facilities in Illinois.

(3) Medicaid bed day calculation shall be based on Medicaid-qualified residents on record as of 30 days prior to the beginning of the assessment quarter in the Department's Medicaid Management Information System, or its successor.

(4) Prior to the collection of the enhanced bed assessment, the Department shall attest that all managed care companies are paying no less than the fee-for-service rate in effect when a service is rendered.

(m) Centers for Medicare and Medicaid Services approval. The Department shall submit initial State Plan amendments to the Centers for Medicare and Medicaid Services no later than 60 days after the effective date of this amendatory Act of the 102nd General Assembly. All amendments and substantive correspondence shall be posted on the Department's website with copies sent to the 4 legislative leaders and members of

the Nursing Facility Oversight Committee. The State Plan amendment shall permit an expedited implementation of the enhanced bed assessment provisions distributed initially through the existing reimbursement system with distribution shifting to the redesigned direct care methodologies when the redesigned methodologies are fully operational. Failure of the Centers for Medicare and Medicaid Services to approve any portion of the reimbursement rate redesigns shall constitute a withdrawal of the General Assembly authorization and necessitate reauthorization prior to moving forward with implementation.

(n) Managed care organization compliance.

(1) The Department shall be responsible for and actively oversee managed care organization compliance and must attest to managed care organization compliance with all provisions of this Section prior to implementing the enhanced bed assessment. The Department shall perform quarterly audits of each managed care organization's business practices to ensure they align with the provisions of this Section. The Department shall immediately modify all contractual arrangements with each of the managed care organizations in conflict with the provisions of this Section. Failure of a managed care organization to agree to all necessary amendments to its contract with the State shall constitute the company's notice of withdrawal from the medical assistance program.

(2) A sanction of $20,000 per incident shall be levied against a managed care organization for failure to comply, which shall double for each subsequent incident of the same or similar violation. All fines shall be deposited into the Long-Term Care Provider Fund. Use of the funds shall be limited to expenditures that qualify for federal matching funds, promote quality of resident care, and have the approval of the Nursing Facility Oversight Committee. Legislative approval, where needed, shall be requested with approval of the Nursing Facility Oversight Committee.

(3) A managed care organization's participation in the medical assistance program shall be terminated for failure to make all necessary changes to business practices in conflict with this Section.

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