

SB3594



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB3594

Introduced 2/5/2026, by Sen. Elgie R. Sims, Jr.

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5.2

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services, beginning January 1, 2027, to recompute the STAR rating of nursing facilities who had their antipsychotic medication quality measure score suppressed and their STAR rating set to one due to audit action by the federal Centers for Medicare and Medicaid Services. Requires quality payments to such nursing facilities to be made based on the recomputed score. Provides that in order to facilitate the recomputation, nursing facilities may provide the Department with documentation regarding the status of the suppression of the score and STAR rating as well as the quarterly report issued by the federal Centers for Medicare and Medicaid Services that lists the long-stay rating points for the quarter.

LRB104 18807 KTG 32250 b

A BILL FOR

1 AN ACT concerning public aid.

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

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

6 (305 ILCS 5/5-5.2)

7 Sec. 5-5.2. Payment.

8 (a) All nursing facilities that are grouped pursuant to
9 Section 5-5.1 of this Act shall receive the same rate of
10 payment for similar services.

11 (b) It shall be a matter of State policy that the Illinois
12 Department shall utilize a uniform billing cycle throughout
13 the State for the long-term care providers.

14 (c) (Blank).

15 (c-1) Notwithstanding any other provisions of this Code,
16 the methodologies for reimbursement of nursing services as
17 provided under this Article shall no longer be applicable for
18 bills payable for nursing services rendered on or after a new
19 reimbursement system based on the Patient Driven Payment Model
20 (PDPM) has been fully operationalized, which shall take effect
21 for services provided on or after the implementation of the
22 PDPM reimbursement system begins. For the purposes of Public
23 Act 102-1035, the implementation date of the PDPM

1 reimbursement system and all related provisions shall be July
2 1, 2022 if the following conditions are met: (i) the Centers
3 for Medicare and Medicaid Services has approved corresponding
4 changes in the reimbursement system and bed assessment; and
5 (ii) the Department has filed rules to implement these changes
6 no later than June 1, 2022. Failure of the Department to file
7 rules to implement the changes provided in Public Act 102-1035
8 no later than June 1, 2022 shall result in the implementation
9 date being delayed to October 1, 2022.

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

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

19 (2) Costs shall be annually rebased and case mix index
20 quarterly updated. The nursing services methodology will
21 be assigned to the Medicaid enrolled residents on record
22 as of 30 days prior to the beginning of the rate period in
23 the Department's Medicaid Management Information System
24 (MMIS) as present on the last day of the second quarter
25 preceding the rate period based upon the Assessment
26 Reference Date of the Minimum Data Set (MDS).

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

5 (4) PDPM nursing case mix indices in effect on March
6 1, 2022 shall be assigned to each resident class at no less
7 than 0.7858 of the Centers for Medicare and Medicaid
8 Services PDPM unadjusted case mix values, in effect on
9 March 1, 2022.

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

13 (6) The Department shall establish a variable per diem
14 staffing add-on in accordance with the most recent
15 available federal staffing report, currently the Payroll
16 Based Journal, for the same period of time, and if
17 applicable adjusted for acuity using the same quarter's
18 MDS. The Department shall rely on Payroll Based Journals
19 provided to the Department of Public Health to make a
20 determination of non-submission. If the Department is
21 notified by a facility of missing or inaccurate Payroll
22 Based Journal data or an incorrect calculation of
23 staffing, the Department must make a correction as soon as
24 the error is verified for the applicable quarter.

25 Beginning October 1, 2024, the staffing percentage
26 used in the calculation of the per diem staffing add-on

1 shall be its PDPM STRIVE Staffing Ratio which equals: its
2 Reported Total Nurse Staffing Hours Per Resident Per Day
3 as published in the most recent federal staffing report
4 (the Provider Information File), divided by the facility's
5 PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE
6 Staffing Target is equal to .82 times the facility's
7 Illinois Adjusted Facility Case-Mix Hours Per Resident Per
8 Day. A facility's Illinois Adjusted Facility Case Mix
9 Hours Per Resident Per Day is equal to its Case-Mix Total
10 Nurse Staffing Hours Per Resident Per Day (as published in
11 the most recent federal Provider Information file) times
12 3.662 (which reflects the national resident days-weighted
13 mean Reported Total Nurse Staffing Hours Per Resident Per
14 Day as calculated using the January 2024 federal Provider
15 Information Files), divided by the national resident
16 days-weighted mean Reported Total Nurse Staffing Hours Per
17 Resident Per Day calculated using the most recent State US
18 Averages file.

19 Beginning January 1, 2025, the staffing percentage
20 used in the calculation of the per diem staffing add-on
21 shall be its PDPM STRIVE Staffing Ratio which equals: its
22 Reported Total Nurse Staffing Hours Per Resident Per Day
23 as published in the most recent federal staffing report
24 (the Provider Information File), divided by the facility's
25 PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE
26 Staffing Target is equal to .7122 times the facility's

1 Illinois Adjusted Facility Case-Mix Hours Per Resident Per
2 Day. A facility's Illinois Adjusted Facility Case Mix
3 Hours Per Resident Per Day is equal to its Case-Mix Total
4 Nurse Staffing Hours Per Resident Per Day (as published in
5 the most recent federal staffing report Provider
6 Information file) times 3.79 (which is the Reported Total
7 Nurse Staffing Hours Per Resident Per Day for the Nation
8 as reported the January 2024 State US Averages file),
9 divided by the Reported Total Nurse Staffing Hours Per
10 Resident Per Day for the Nation as reported in the most
11 recent State US Averages file.

12 (6.5) Beginning July 1, 2024, the paid per diem
13 staffing add-on shall be the paid per diem staffing add-on
14 in effect April 1, 2024. For dates beginning October 1,
15 2024 and through September 30, 2025, the denominator for
16 the staffing percentage shall be the lesser of the
17 facility's PDPM STRIVE Staffing Target and:

18 (A) For the quarter beginning October 1, 2024, the
19 sum of 20% of the facility's PDPM STRIVE Staffing
20 Target and 80% of the facility's Case-Mix Total Nurse
21 Staffing Hours Per Resident Per Day (as published in
22 the January 2024 federal staffing report).

23 (B) For the quarter beginning January 1, 2025, the
24 sum of 40% of the facility's PDPM STRIVE Staffing
25 Target and 60% of the facility's Case-Mix Total Nurse
26 Staffing Hours Per Resident Per Day (as published in

1 the January 2024 federal staffing report).

2 (C) For the quarter beginning March 1, 2025, the
3 sum of 60% of the facility's PDPM STRIVE Staffing
4 Target and 40% of the facility's Case-Mix Total Nurse
5 Staffing Hours Per Resident Per Day (as published in
6 the January 2024 federal staffing report).

7 (D) For the quarter beginning July 1, 2025, the
8 sum of 80% of the facility's PDPM STRIVE Staffing
9 Target and 20% of the facility's Case-Mix Total Nurse
10 Staffing Hours Per Resident Per Day (as published in
11 the January 2024 federal staffing report).

12 Facilities with at least 70% of the staffing
13 indicated by the STRIVE study shall be paid a per diem
14 add-on of \$9, increasing by equivalent steps for each
15 whole percentage point until the facilities reach a per
16 diem of \$16.52. Facilities with at least 80% of the
17 staffing indicated by the STRIVE study shall be paid a per
18 diem add-on of \$16.52, increasing by equivalent steps for
19 each whole percentage point until the facilities reach a
20 per diem add-on of \$25.77. Facilities with at least 92% of
21 the staffing indicated by the STRIVE study shall be paid a
22 per diem add-on of \$25.77, increasing by equivalent steps
23 for each whole percentage point until the facilities reach
24 a per diem add-on of \$30.98. Facilities with at least 100%
25 of the staffing indicated by the STRIVE study shall be
26 paid a per diem add-on of \$30.98, increasing by equivalent

1 steps for each whole percentage point until the facilities
2 reach a per diem add-on of \$36.44. Facilities with at
3 least 110% of the staffing indicated by the STRIVE study
4 shall be paid a per diem add-on of \$36.44, increasing by
5 equivalent steps for each whole percentage point until the
6 facilities reach a per diem add-on of \$38.68. Facilities
7 with at least 125% or higher of the staffing indicated by
8 the STRIVE study shall be paid a per diem add-on of \$38.68.
9 No nursing facility's variable staffing per diem add-on
10 shall be reduced by more than 5% in 2 consecutive
11 quarters. For the quarters beginning July 1, 2022 and
12 October 1, 2022, no facility's variable per diem staffing
13 add-on shall be calculated at a rate lower than 85% of the
14 staffing indicated by the STRIVE study. No facility below
15 70% of the staffing indicated by the STRIVE study shall
16 receive a variable per diem staffing add-on after December
17 31, 2022.

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

1 the PDPM nursing component per diem or:

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

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

8 (C) for the quarter beginning January 1, 2023, the
9 sum of the RUG-IV nursing component per diem
10 multiplied by 0.60 and the PDPM nursing component per
11 diem multiplied by 0.40;

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

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

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

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

26 (1) Base rate spending pool shall be:

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

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

8 (C) Thirteen million is added to the product of
9 subparagraph (A) and subparagraph (B) to adjust for
10 the exclusion of nursing homes defined in paragraph
11 (5).

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

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

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

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

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

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

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

9 (B) on and after July 1, 2014 and until July 1,
10 2022, shall be the amount calculated under
11 subparagraph (A) of this paragraph (3) plus \$1.76; and

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

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

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

25 (e) Beginning July 1, 2014, the Department shall allocate
26 funding in the amount up to \$10,000,000 for per diem add-ons to

1 the RUGS methodology for dates of service on and after July 1,
2 2014:

3 (1) \$0.63 for each resident who scores in I4200
4 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

5 (2) \$2.67 for each resident who scores either a "1" or
6 "2" in any items S1200A through S1200I and also scores in
7 RUG groups PA1, PA2, BA1, or BA2.

8 (e-1) (Blank).

9 (e-2) For dates of services beginning January 1, 2014 and
10 ending September 30, 2023, the RUG-IV nursing component per
11 diem for a nursing home shall be the product of the statewide
12 RUG-IV nursing base per diem rate, the facility average case
13 mix index, and the regional wage adjustor. For dates of
14 service beginning July 1, 2022 and ending September 30, 2023,
15 the Medicaid access adjustment described in subsection (e-3)
16 shall be added to the product.

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

1 subsection shall be inoperative on and after January 1, 2028.

2 (e-4) Subject to federal approval, on and after January 1,
3 2024, the Department shall increase the rate add-on at
4 paragraph (7) subsection (a) under 89 Ill. Adm. Code 147.335
5 for ventilator services from \$208 per day to \$481 per day.
6 Payment is subject to the criteria and requirements under 89
7 Ill. Adm. Code 147.335.

8 (f) (Blank).

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

14 (1) (Blank);

15 (2) (Blank);

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

18 (h) Notwithstanding any other provision of this Code, on
19 and after July 1, 2012, nursing facilities designated by the
20 Department of Healthcare and Family Services as "Institutions
21 for Mental Disease" and "Institutions for Mental Disease" that
22 are facilities licensed under the Specialized Mental Health
23 Rehabilitation Act of 2013 shall have the nursing,
24 socio-developmental, capital, and support components of their
25 reimbursement rate effective May 1, 2011 reduced in total by
26 2.7%.

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

6 (i-1) Subject to federal approval, on and after January 1,
7 2024, the reimbursement rates for the support component of the
8 nursing facility rate for facilities licensed under the
9 Nursing Home Care Act as skilled or intermediate care
10 facilities shall be the rate in effect on June 30, 2023
11 increased by 12%.

12 (j) Notwithstanding any other provision of law, subject to
13 federal approval, effective July 1, 2019, sufficient funds
14 shall be allocated for changes to rates for facilities
15 licensed under the Nursing Home Care Act as skilled nursing
16 facilities or intermediate care facilities for dates of
17 services on and after July 1, 2019: (i) to establish, through
18 June 30, 2022 a per diem add-on to the direct care per diem
19 rate not to exceed \$70,000,000 annually in the aggregate
20 taking into account federal matching funds for the purpose of
21 addressing the facility's unique staffing needs, adjusted
22 quarterly and distributed by a weighted formula based on
23 Medicaid bed days on the last day of the second quarter
24 preceding the quarter for which the rate is being adjusted.
25 Beginning July 1, 2022, the annual \$70,000,000 described in
26 the preceding sentence shall be dedicated to the variable per

1 diem add-on for staffing under paragraph (6) of subsection
2 (d); and (ii) in an amount not to exceed \$170,000,000 annually
3 in the aggregate taking into account federal matching funds to
4 permit the support component of the nursing facility rate to
5 be updated as follows:

6 (1) 80%, or \$136,000,000, of the funds shall be used
7 to update each facility's rate in effect on June 30, 2019
8 using the most recent cost reports on file, which have had
9 a limited review conducted by the Department of Healthcare
10 and Family Services and will not hold up enacting the rate
11 increase, with the Department of Healthcare and Family
12 Services.

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

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

21 (k) During the first quarter of State Fiscal Year 2020,
22 the Department of Healthcare of Family Services must convene a
23 technical advisory group consisting of members of all trade
24 associations representing Illinois skilled nursing providers
25 to discuss changes necessary with federal implementation of
26 Medicare's Patient-Driven Payment Model. Implementation of

1 Medicare's Patient-Driven Payment Model shall, by September 1,
2 2020, end the collection of the MDS data that is necessary to
3 maintain the current RUG-IV Medicaid payment methodology. The
4 technical advisory group must consider a revised reimbursement
5 methodology that takes into account transparency,
6 accountability, actual staffing as reported under the
7 federally required Payroll Based Journal system, changes to
8 the minimum wage, adequacy in coverage of the cost of care, and
9 a quality component that rewards quality improvements.

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

13 (1) Incentive payments determined by facility
14 performance on specified quality measures in an initial
15 amount of \$70,000,000. Nothing in this subsection shall be
16 construed to limit the quality of care payments in the
17 aggregate statewide to \$70,000,000, and, if quality of
18 care has improved across nursing facilities, the
19 Department shall adjust those add-on payments accordingly.
20 The quality payment methodology described in this
21 subsection must be used for at least State Fiscal Year
22 2023. Beginning with the quarter starting July 1, 2023,
23 the Department may add, remove, or change quality metrics
24 and make associated changes to the quality payment
25 methodology as outlined in subparagraph (E). Facilities
26 designated by the Centers for Medicare and Medicaid

1 Services as a special focus facility or a hospital-based
2 nursing home do not qualify for quality payments.

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

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

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

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

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

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

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

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

26 (D) The quality pool is no less than \$70,000,000

1 annually or \$17,500,000 per quarter. The Department
2 shall publish on its website the estimated payments
3 and the associated weights for each facility 45 days
4 prior to when the initial payments for the quarter are
5 to be paid. The Department shall assign each facility
6 the most recent and applicable quarter's STAR value
7 unless the facility notifies the Department within 15
8 days of an issue and the facility provides reasonable
9 evidence demonstrating its timely compliance with
10 federal data submission requirements for the quarter
11 of record. If such evidence cannot be provided to the
12 Department, the STAR rating assigned to the facility
13 shall be reduced by one from the prior quarter.

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

24 (F) The Department shall disburse quality pool
25 payments from the Long-Term Care Provider Fund on a
26 monthly basis in amounts proportional to the total

1 quality pool payment determined for the quarter.

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

7 (H) Beginning January 1, 2027, for facilities that
8 have had their long-stay percentage of residents who
9 received an antipsychotic medication quality measure
10 score suppressed and their STAR rating set to one due
11 to audit action by the federal Centers for Medicare
12 and Medicaid Services, the Department shall recompute
13 the facility's STAR rating using the actual long-stay
14 rating points for the quarter per the methodology used
15 by the federal Centers for Medicare and Medicaid
16 Services. Quality payments shall be made based on the
17 recomputed score.

18 In order to facilitate the evaluation and
19 completion of the recomputation required in this
20 subparagraph, facilities may provide the Department
21 with documentation regarding the status of the
22 suppression of the score and STAR rating as well as the
23 quarterly report issued by the federal Centers for
24 Medicare and Medicaid Services that lists the
25 long-stay rating points for the quarter.

26 (2) Payments based on CNA tenure, promotion, and CNA

1 training for the purpose of increasing CNA compensation.
2 It is the intent of this subsection that payments made in
3 accordance with this paragraph be directly incorporated
4 into increased compensation for CNAs. As used in this
5 paragraph, "CNA" means a certified nursing assistant as
6 that term is described in Section 3-206 of the Nursing
7 Home Care Act, Section 3-206 of the ID/DD Community Care
8 Act, and Section 3-206 of the MC/DD Act. The Department
9 shall establish, by rule, payments to nursing facilities
10 equal to Medicaid's share of the tenure wage increments
11 specified in this paragraph for all reported CNA employee
12 hours compensated according to a posted schedule
13 consisting of increments at least as large as those
14 specified in this paragraph. The increments are as
15 follows: an additional \$1.50 per hour for CNAs with at
16 least one and less than 2 years' experience plus another
17 \$1 per hour for each additional year of experience up to a
18 maximum of \$6.50 for CNAs with at least 6 years of
19 experience. For purposes of this paragraph, Medicaid's
20 share shall be the ratio determined by paid Medicaid bed
21 days divided by total bed days for the applicable time
22 period used in the calculation. In addition, and additive
23 to any tenure increments paid as specified in this
24 paragraph, the Department shall establish, by rule,
25 payments supporting Medicaid's share of the
26 promotion-based wage increments for CNA employee hours

1 compensated for that promotion with at least a \$1.50
2 hourly increase. Medicaid's share shall be established as
3 it is for the tenure increments described in this
4 paragraph. Qualifying promotions shall be defined by the
5 Department in rules for an expected 10-15% subset of CNAs
6 assigned intermediate, specialized, or added roles such as
7 CNA trainers, CNA scheduling "captains", and CNA
8 specialists for resident conditions like dementia or
9 memory care or behavioral health.

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

15 (Source: P.A. 102-77, eff. 7-9-21; 102-558, eff. 8-20-21;
16 102-1035, eff. 5-31-22; 102-1118, eff. 1-18-23; 103-102,
17 Article 40, Section 40-5, eff. 1-1-24; 103-102, Article 50,
18 Section 50-5, eff. 1-1-24; 103-593, eff. 6-7-24; 103-605, eff.
19 7-1-24; 103-1075, eff. 3-21-25.)