



## 102ND GENERAL ASSEMBLY

### State of Illinois

2021 and 2022

**HB4678**

Introduced 1/21/2022, by Rep. Anna Moeller

#### SYNOPSIS AS INTRODUCED:

See Index

Amends the Nurse Agency Licensing Act. Prohibits nurse agencies from entering into covenants not to compete with nurses and certified nurse aides who are employed by the agencies. Provides that a supplemental healthcare staffing agency must not bill nor receive payments from a licensed health care facility at a rate higher than 130% of the sum of total compensation plus associated payroll taxes for applicable employee classifications. Provides that the maximum charge must include all charges for administrative fees, contract fees, or other special charges in addition to compensation for the temporary nursing pool personnel supplied to a health care facility. Amends the Illinois Public Aid Code. Provides that it shall be a matter of State policy that the Department of Healthcare and Family Services shall set nursing facility rates, by rule, utilizing an evidence-based methodology that rewards appropriate staffing, quality-of-life improvements for nursing facility residents, and the reduction of racial inequities and health disparities for nursing facility residents enrolled in Medicaid. Contains provisions concerning the Patient Driven Payment Model for nursing services reimbursements; utilization of the Staff Time and Resource Intensity Verification study; the statewide base rate for certain dates of service; the establishment of a variable per diem add-on for nursing facilities with specified staffing levels; directed payments to improve the quality of care delivered by nursing facilities; occupied bed tax amounts beginning January 1, 2022, emergency rules; and other matters. Schedules for repeal on July 1, 2024 the Nursing Home License Fee Article of the Code. Amends the Illinois Administrative Procedure Act. Permits the Department of Healthcare and Family Services to adopt emergency rules to implement certain changes made by the amendatory Act. Effective immediately.

LRB102 24964 KTG 34219 b

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 Administrative Procedure Act is  
5 amended by adding Section 5-45.21 as follows:

6 (5 ILCS 100/5-45.21 new)

7 Sec. 5-45.21. Emergency rulemaking; Department of  
8 Healthcare and Family Services. To provide for the expeditious  
9 and timely implementation of changes made to Section 5-5.2 of  
10 the Illinois Public Aid Code by this amendatory Act of the  
11 102nd General Assembly, emergency rules implementing the such  
12 changes may be adopted in accordance with Section 5-45 by the  
13 Department of Healthcare and Family Services. The adoption of  
14 emergency rules authorized by Section 5-45 and this Section is  
15 deemed to be necessary for the public interest, safety, and  
16 welfare.

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

19 Section 10. The Nurse Agency Licensing Act is amended by  
20 changing Sections 3 and 14 as follows:

21 (225 ILCS 510/3) (from Ch. 111, par. 953)

1           Sec. 3. Definitions. As used in this Act:

2           (a) "Certified nurse aide" means an individual certified  
3 as defined in Section 3-206 of the Nursing Home Care Act,  
4 Section 3-206 of the ID/DD Community Care Act, or Section  
5 3-206 of the MC/DD Act, as now or hereafter amended.

6           (b) "Department" means the Department of Labor.

7           (c) "Director" means the Director of Labor.

8           (d) "Health care facility" is defined as in Section 3 of  
9 the Illinois Health Facilities Planning Act, as now or  
10 hereafter amended.

11           (e) "Licensee" means any nursing agency which is properly  
12 licensed under this Act.

13           (f) "Nurse" means a registered nurse or a licensed  
14 practical nurse as defined in the Nurse Practice Act.

15           (g) "Nurse agency" means any individual, firm,  
16 corporation, partnership or other legal entity that employs,  
17 assigns or refers nurses or certified nurse aides to a health  
18 care facility for a fee. The term "nurse agency" includes  
19 nurses registries. The term "nurse agency" does not include  
20 services provided by home health agencies licensed and  
21 operated under the Home Health, Home Services, and Home  
22 Nursing Agency Licensing Act or a licensed or certified  
23 individual who provides his or her own services as a regular  
24 employee of a health care facility, nor does it apply to a  
25 health care facility's organizing nonsalaried employees to  
26 provide services only in that facility.

1       (h) "Covenant not to compete" means an agreement between  
2 an employer and an employee that restricts such employee from  
3 performing:

4           (1) any work for another employer for a specified  
5 period of time;

6           (2) any work in a specified geographical area; or

7           (3) work for another employer that is similar to such  
8 employee's work for the employer included as a party to  
9 the agreement.

10       (Source: P.A. 98-104, eff. 7-22-13; 99-180, eff. 7-29-15.)

11       (225 ILCS 510/14) (from Ch. 111, par. 964)

12       Sec. 14. Minimum Standards. (a) The Department, by rule,  
13 shall establish minimum standards for the operation of nurse  
14 agencies. Those standards shall include, but are not limited  
15 to: (1) the maintenance of written policies and procedures;  
16 and (2) the development of personnel policies which include a  
17 personal interview, a reference check, an annual evaluation of  
18 each employee (which may be based in part upon information  
19 provided by health care facilities utilizing nurse agency  
20 personnel) and periodic health examinations.

21       (b) Each nurse agency shall have a nurse serving as a  
22 manager or supervisor of all nurses and certified nurses  
23 aides.

24       (c) Each nurse agency shall ensure that its employees meet  
25 the minimum licensing, training, and orientation standards for

1 which those employees are licensed or certified.

2 (d) A nurse agency shall not employ, assign, or refer for  
3 use in an Illinois health care facility a nurse or certified  
4 nurse aide unless certified or licensed under applicable  
5 provisions of State and federal law or regulations. Each  
6 certified nurse aide shall comply with all pertinent  
7 regulations of the Illinois Department of Public Health  
8 relating to the health and other qualifications of personnel  
9 employed in health care facilities.

10 (e) The Department may adopt rules to monitor the usage of  
11 nurse agency services to determine their impact.

12 (f) Nurse agencies are prohibited from requiring, as a  
13 condition of employment, assignment, or referral, that their  
14 employees recruit new employees for the nurse agency from  
15 among the permanent employees of the health care facility to  
16 which the nurse agency employees have been employed, assigned,  
17 or referred, and the health care facility to which such  
18 employees are employed, assigned, or referred is prohibited  
19 from requiring, as a condition of employment, that their  
20 employees recruit new employees from these nurse agency  
21 employees. Violation of this provision is a business offense.

22 (g) Nurse agencies are prohibited from entering into  
23 covenants not to compete with nurses and certified nurse aides  
24 who are employed by the agencies. After the effective date of  
25 this amendatory Act of the 102nd General Assembly, a covenant  
26 not to compete entered into between a nurse agency and a

1 certified nurse aide is illegal and void.

2 (h) Maximum charges. A supplemental healthcare staffing  
3 agency must not bill nor receive payments from a health care  
4 facility licensed by the State at a rate higher than 130% of  
5 the sum of total compensation plus associated payroll taxes  
6 for applicable employee classifications. Agencies must submit  
7 a confidential report to the Department of Employment Security  
8 on a quarterly basis the sum of total compensation plus  
9 associated payroll taxes for all applicable employee  
10 classifications, and shall separately include in this report  
11 the total revenue received from health care facilities  
12 licensed by the State for the same period for these employees,  
13 thereby enabling the Department's calculation of the ratio of  
14 these 2 totals. This ratio shall be used by the Department to  
15 determine compliance with this maximum charge provision, and  
16 the veracity of the underlying data shall be subject to audit  
17 by the Department as well as by the Auditor General. For  
18 purposes of this subsection, total compensation shall include,  
19 at a minimum, wages defined as hourly rate of pay and shift  
20 differential, including weekend shift differential and  
21 overtime.

22 The maximum charge must include all charges for  
23 administrative fees, contract fees, or other special charges  
24 in addition to compensation for the temporary nursing pool  
25 personnel supplied to a health care facility. A health care  
26 facility that pays for the actual travel and housing costs for

1 supplemental healthcare staffing agency staff working at the  
2 facility and that pays these costs to the employee, the  
3 agency, or another vendor, is not required to count these  
4 costs as total compensation.

5 (Source: P.A. 86-817.)

6 Section 15. The Illinois Public Aid Code is amended by  
7 changing Sections 5-5.2, 5B-2, 5B-4, 5B-5, 5B-8, 5E-10, and by  
8 adding Section 5E-20 as follows:

9 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

10 Sec. 5-5.2. Payment.

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

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

17 (b-1) It shall be a matter of State policy that the  
18 Department shall set nursing facility rates, by rule,  
19 utilizing an evidence-based methodology that rewards  
20 appropriate staffing, quality-of-life improvements for nursing  
21 facility residents, and the reduction of racial inequities and  
22 health disparities for nursing facility residents enrolled in  
23 Medicaid.

24 (c) (Blank). ~~Notwithstanding any other provisions of this~~

1 ~~Code, the methodologies for reimbursement of nursing services~~  
2 ~~as provided under this Article shall no longer be applicable~~  
3 ~~for bills payable for nursing services rendered on or after a~~  
4 ~~new reimbursement system based on the Resource Utilization~~  
5 ~~Groups (RUGs) has been fully operationalized, which shall take~~  
6 ~~effect for services provided on or after January 1, 2014.~~

7 (d) The new nursing services reimbursement methodology  
8 utilizing the Patient Driven Payment Model ~~RUG IV 48 grouper~~  
9 ~~model~~, which shall be referred to as the PDPM ~~RUGs~~  
10 reimbursement system, taking effect January 1, 2022, upon  
11 federal approval by the Centers for Medicare and Medicaid  
12 Services 2014, shall be based on the following:

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

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

25 (3) Regional wage adjustors based on the Health  
26 Service Areas (HSA) groupings and adjusters in effect on



1 January 1, 2022 ~~April 30, 2012~~ shall be included, except  
2 no adjuster shall be lower than 1.0.

3 (4) PDPM nursing case-mix indices in effect on May 1,  
4 2021 Case mix index shall be assigned to each resident  
5 class based on the Centers for Medicare and Medicaid  
6 Services staff time measurement study called Staff Time  
7 and Resource Intensity Verification (STRIVE) in effect on  
8 July 1, 2013, adjusted by a uniform multiplier to achieve  
9 the same statewide case mix index value observed for the  
10 quarter beginning April 1, 2021 while holding PA1, PA2,  
11 BA1, and BB1 resident classes at the level applicable  
12 under the RUG-IV payment model prior to January 1, 2022  
13 utilizing an index maximization approach.

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

18 (6) The statewide base rate for dates of service  
19 before January 1, 2022 shall be \$85.25, and thereafter  
20 shall be no less than \$90.25.

21 (7) The Department shall establish a variable per diem  
22 add-on based on information from the most recent available  
23 federal staffing report, currently the Payroll Based  
24 Journal, adjusted for acuity if applicable using the same  
25 quarter's MDS. The variable per diem add-on shall be paid  
26 only to facilities with at least 70% of the staffing

1 indicated by the STRIVE study. For facilities at 70% of  
2 the staffing indicated by the STRIVE study, those  
3 facilities shall be paid a per diem add-on of \$9,  
4 increasing by equivalent steps for each whole percentage  
5 point of improvement until the facilities reach a per diem  
6 of \$14.88. For facilities with at least 80% of the  
7 staffing indicated by the STRIVE study, those facilities  
8 shall be paid a per diem add-on of \$14.88, increasing by  
9 equivalent steps for each whole percentage point of  
10 improvement until the facilities reach a per diem add-on  
11 of \$23.80. For facilities with at least 92% of the  
12 staffing indicated by the STRIVE study, those facilities  
13 shall be paid a per diem add-on of \$23.80, increasing by  
14 equivalent steps for each whole percentage point of  
15 improvement until the facilities reach a per diem add-on  
16 of \$29.75. For facilities with at least 100% of the  
17 staffing indicated by the STRIVE study, those facilities  
18 shall be paid a per diem add-on of \$29.75, increasing by  
19 equivalent steps for each whole percentage point of  
20 improvement until the facilities reach a per diem add-on  
21 of \$35.70. For facilities with at least 110% of the  
22 staffing indicated by the STRIVE study, those facilities  
23 shall be paid a per diem add-on of \$35.70, increasing by  
24 equivalent steps for each whole percentage point of  
25 improvement until the facilities reach a per diem add-on  
26 of \$38.68. For facilities with 125% of the staffing

1 indicated by the STRIVE study or more, those facilities  
2 shall be paid a per diem add-on of \$38.68. The Department  
3 shall establish, by rule, a limit of not more than a 5  
4 percentage point drop per once-consecutive quarter in the  
5 STRIVE percentage used to determine the variable per diem  
6 add-on.

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

9 ~~(1) Base rate spending pool shall be:~~

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

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

17 ~~(C) Thirteen million is added to the product of~~  
18 ~~subparagraph (A) and subparagraph (B) to adjust for~~  
19 ~~the exclusion of nursing homes defined in paragraph~~  
20 ~~(5).~~

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

26 ~~(A) Base year resident days as calculated in~~

1 ~~subparagraph (A) of paragraph (1).~~

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

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

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

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

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

18 ~~(B) on and after July 1, 2014, shall be the amount~~  
19 ~~calculated under subparagraph (A) of this paragraph~~  
20 ~~(3) plus \$1.76.~~

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

24 ~~(5) Nursing facilities designated as of July 1, 2012~~  
25 ~~by the Department as "Institutions for Mental Disease"~~  
26 ~~shall be excluded from all calculations under this~~

1 ~~subsection. The data from these facilities shall not be~~  
2 ~~used in the computations described in paragraphs (1)~~  
3 ~~through (4) above to establish the base rate.~~

4 (e) Beginning July 1, 2014 through December 31, 2021, the  
5 Department shall allocate funding in the amount up to  
6 \$10,000,000 for per diem add-ons to the RUGS methodology for  
7 dates of service on and after July 1, 2014:

8 (1) \$0.63 for each resident who scores in I4200  
9 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

10 (2) \$2.67 for each resident who scores either a "1" or  
11 "2" in any items S1200A through S1200I and also scores in  
12 RUG groups PA1, PA2, BA1, or BA2.

13 (3) Beginning on January 1, 2022, the Department shall  
14 allocate funding, by rule, for per diem add-ons to the  
15 PDPM methodology for each resident with a diagnosis of  
16 Alzheimer's disease.

17 (e-1) (Blank).

18 (e-2) (Blank). ~~For dates of services beginning January 1,~~  
19 ~~2014, the RUG IV nursing component per diem for a nursing home~~  
20 ~~shall be the product of the statewide RUG-IV nursing base per~~  
21 ~~diem rate, the facility average case mix index, and the~~  
22 ~~regional wage adjustor. Transition rates for services provided~~  
23 ~~between January 1, 2014 and December 31, 2014 shall be as~~  
24 ~~follows:~~

25 ~~(1) The transition RUG-IV per diem nursing rate for~~  
26 ~~nursing homes whose rate calculated in this subsection~~

1 ~~(e-2) is greater than the nursing component rate in effect~~  
2 ~~July 1, 2012 shall be paid the sum of:~~

3 ~~(A) The nursing component rate in effect July 1,~~  
4 ~~2012; plus~~

5 ~~(B) The difference of the RUG IV nursing component~~  
6 ~~per diem calculated for the current quarter minus the~~  
7 ~~nursing component rate in effect July 1, 2012~~  
8 ~~multiplied by 0.88.~~

9 ~~(2) The transition RUG IV per diem nursing rate for~~  
10 ~~nursing homes whose rate calculated in this subsection~~  
11 ~~(e-2) is less than the nursing component rate in effect~~  
12 ~~July 1, 2012 shall be paid the sum of:~~

13 ~~(A) The nursing component rate in effect July 1,~~  
14 ~~2012; plus~~

15 ~~(B) The difference of the RUG IV nursing component~~  
16 ~~per diem calculated for the current quarter minus the~~  
17 ~~nursing component rate in effect July 1, 2012~~  
18 ~~multiplied by 0.13.~~

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

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

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

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

8 (2) (Blank); ~~Individual nursing rates for residents~~  
9 ~~classified in all other RUG IV groups shall be reduced by~~  
10 ~~1.0%;~~

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

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

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

1 (j) Notwithstanding any other provision of law, subject to  
2 federal approval, effective July 1, 2019, sufficient funds  
3 shall be allocated for changes to rates for facilities  
4 licensed under the Nursing Home Care Act as skilled nursing  
5 facilities or intermediate care facilities for dates of  
6 services on and after July 1, 2019: (i) to establish, through  
7 December 31, 2021 or upon implementation of the variable per  
8 diem add-on for staffing under paragraph (7) of subsection  
9 (d), whichever is later, a per diem add-on to the direct care  
10 per diem rate not to exceed \$70,000,000 annually in the  
11 aggregate taking into account federal matching funds for the  
12 purpose of addressing the facility's unique staffing needs,  
13 adjusted quarterly and distributed by a weighted formula based  
14 on Medicaid bed days on the last day of the second quarter  
15 preceding the quarter for which the rate is being adjusted.  
16 Beginning January 1, 2022, or upon implementation of the  
17 variable per diem add-on for staffing under paragraph (7) of  
18 subsection (d), whichever is later, the annual \$70,000,000  
19 described in the preceding sentence shall be dedicated to the  
20 variable per diem add-on for staffing under paragraph (7) of  
21 subsection (d); and (ii) in an amount not to exceed  
22 \$170,000,000 annually in the aggregate taking into account  
23 federal matching funds to permit the support component of the  
24 nursing facility rate to be updated as follows:

25 (1) 80%, or \$136,000,000, of the funds shall be used  
26 to update each facility's rate in effect on June 30, 2019



1 using the most recent cost reports on file, which have had  
2 a limited review conducted by the Department of Healthcare  
3 and Family Services and will not hold up enacting the rate  
4 increase, with the Department of Healthcare and Family  
5 Services ~~and taking into account subsection (i)~~.

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

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

14 In order to provide for the expeditious and timely  
15 implementation of the provisions of this amendatory Act of the  
16 102nd General Assembly, emergency rules to implement any  
17 provision of this amendatory Act of the 102nd General Assembly  
18 may be adopted in accordance with this subsection by the  
19 agency charged with administering that provision or  
20 initiative. The 24-month limitation on the adoption of  
21 emergency rules does not apply to rules adopted under this  
22 subsection. The adoption of emergency rules authorized by this  
23 subsection is deemed to be necessary for the public interest,  
24 safety, and welfare.

25 ~~To implement item (i) in this subsection, facilities shall~~  
26 ~~file quarterly reports documenting compliance with its~~

1 ~~annually approved staffing plan, which shall permit compliance~~  
2 ~~with Section 3-202.05 of the Nursing Home Care Act. A facility~~  
3 ~~that fails to meet the benchmarks and dates contained in the~~  
4 ~~plan may have its add-on adjusted in the quarter following the~~  
5 ~~quarterly review. Nothing in this Section shall limit the~~  
6 ~~ability of the facility to appeal a ruling of non compliance~~  
7 ~~and a subsequent reduction to the add-on. Funds adjusted for~~  
8 ~~noncompliance shall be maintained in the Long Term Care~~  
9 ~~Provider Fund and accounted for separately. At the end of each~~  
10 ~~fiscal year, these funds shall be made available to facilities~~  
11 ~~for special staffing projects.~~

12 ~~In order to provide for the expeditious and timely~~  
13 ~~implementation of the provisions of Public Act 101-10,~~  
14 ~~emergency rules to implement any provision of Public Act~~  
15 ~~101-10 may be adopted in accordance with this subsection by~~  
16 ~~the agency charged with administering that provision or~~  
17 ~~initiative. The agency shall simultaneously file emergency~~  
18 ~~rules and permanent rules to ensure that there is no~~  
19 ~~interruption in administrative guidance. The 150 day~~  
20 ~~limitation of the effective period of emergency rules does not~~  
21 ~~apply to rules adopted under this subsection, and the~~  
22 ~~effective period may continue through June 30, 2021. The~~  
23 ~~24-month limitation on the adoption of emergency rules does~~  
24 ~~not apply to rules adopted under this subsection. The adoption~~  
25 ~~of emergency rules authorized by this subsection is deemed to~~  
26 ~~be necessary for the public interest, safety, and welfare.~~

1 (k) During the first quarter of State Fiscal Year 2020,  
2 the Department of Healthcare of Family Services must convene a  
3 technical advisory group consisting of members of all trade  
4 associations representing Illinois skilled nursing providers  
5 to discuss changes necessary with federal implementation of  
6 Medicare's Patient-Driven Payment Model. Implementation of  
7 Medicare's Patient-Driven Payment Model shall, by September 1,  
8 2020, end the collection of the MDS data that is necessary to  
9 maintain the current RUG-IV Medicaid payment methodology. The  
10 technical advisory group must consider a revised reimbursement  
11 methodology that takes into account transparency,  
12 accountability, actual staffing as reported under the  
13 federally required Payroll Based Journal system, changes to  
14 the minimum wage, adequacy in coverage of the cost of care, and  
15 a quality component that rewards quality improvements.

16 (1) The Department shall establish directed payments to  
17 improve the quality of care delivered by facilities,  
18 including:

19 (1) Incentive payments determined by facility  
20 performance on specified quality measures in an initial  
21 amount of \$70,000,000. Nothing in this Section shall be  
22 construed to limit the quality of care directed payments  
23 to \$70,000,000, and in the case that quality of care has  
24 improved across nursing facilities, the Department shall  
25 adjust those directed payments accordingly. The quality  
26 payment methodology described in this Section must be used

1 for at least the first 2 quarters in calendar year 2022.  
2 Beginning with the quarter starting July 1, 2022, the  
3 Department may add, remove, or change quality metrics and  
4 make associated changes to the quality payment methodology  
5 as outlined in subparagraph (E). Facilities designated by  
6 the Centers for Medicare and Medicaid Services as a  
7 special focus facility or a hospital-based nursing home do  
8 not qualify for quality payments.

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

14 (B) Star rating weights are assigned based on the  
15 nursing home's star rating for the LTS quality star  
16 rating. "LTS quality star rating" means the long stay  
17 quality rating for each nursing facility as assigned  
18 by the Centers for Medicare and Medicaid Services  
19 under the Five-Star Quality Rating System. The rating  
20 is a number ranging from 0 (lowest) to 5 (highest).

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

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

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

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

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

26 (C) Each nursing home's quality weight score is

1 divided by the sum of all quality weight scores for  
2 qualifying nursing homes to determine the proportion  
3 of the quality pool to be paid to the nursing home.

4 (D) The quality pool is no less than \$70,000,000  
5 annually or \$17,500,000 per quarter.

6 (E) The Department shall review quality metrics  
7 used for payment of the quality pool and make  
8 recommendations for any associated changes to the  
9 methodology for distributing quality pool payments to  
10 a quality review committee established by the  
11 Department consisting of associations representing  
12 long-term care providers, consumer advocates,  
13 organizations representing workers of long-term care  
14 facilities, and payors.

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

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

25 (2) Payments based on CNA tenure, promotion, and CNA  
26 training for the purpose of increasing CNA compensation.

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

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

9 (m) In order to provide for the expeditious and timely  
10 implementation of the provisions of this amendatory Act of the  
11 102nd General Assembly, emergency rules to implement any  
12 provision of this amendatory Act of the 102nd General Assembly  
13 may be adopted in accordance with this subsection by the  
14 agency charged with administering that provision or  
15 initiative. The 24-month limitation on the adoption of  
16 emergency rules does not apply to rules adopted under this  
17 subsection. The adoption of emergency rules authorized by this  
18 subsection is deemed to be necessary for the public interest,  
19 safety, and welfare.

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

22 (305 ILCS 5/5B-2) (from Ch. 23, par. 5B-2)

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

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

1 December 31, 2021, or upon federal approval by the Centers for  
2 Medicare and Medicaid Services of the long-term care provider  
3 assessment described in subsection (a-1), whichever is later,  
4 an assessment is imposed upon each long-term care provider in  
5 an amount equal to \$6.07 times the number of occupied bed days  
6 due and payable each month. Notwithstanding any provision of  
7 any other Act to the contrary, this assessment shall be  
8 construed as a tax, but shall not be billed or passed on to any  
9 resident of a nursing home operated by the nursing home  
10 provider.

11 (a-1) For the privilege of engaging in the occupation of  
12 long-term care provider, beginning January 1, 2022, an  
13 assessment is imposed upon each long-term care provider in an  
14 amount varying with the number of paid Medicaid resident days  
15 per annum in the facility with the following initial schedule  
16 of occupied bed tax amounts:

17 (1) 0-5,000 Medicaid resident days per annum, \$10.67.

18 (2) 5,001-15,000 Medicaid resident days per annum,  
19 \$19.20.

20 (3) 15,001-35,000 Medicaid resident days per annum,  
21 \$22.40.

22 (4) 35,001-55,000 Medicaid resident days per annum,  
23 \$19.20.

24 (5) 55,001-65,000 Medicaid resident days per annum,  
25 \$13.86.

26 (6) 65,001+ Medicaid resident days per annum, \$10.67.



1           (7) Any nonprofit nursing facilities without  
2           Medicaid-certified beds, \$7 per occupied bed day.

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

7           Each facility's paid Medicaid resident days per annum  
8           shall be updated annually for the purpose of determining the  
9           appropriate tax rate.

10          Implementation of the assessment described in this  
11          subsection shall be subject to federal approval by the Centers  
12          for Medicare and Medicaid Services.

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

20           (c) The assessment imposed by this Section shall not be  
21           due and payable, however, until after the Department notifies  
22           the long-term care providers, in writing, that the payment  
23           methodologies to long-term care providers required under  
24           Section 5-5.2 ~~5-5.4~~ of this Code have been approved by the  
25           Centers for Medicare and Medicaid Services of the U.S.  
26           Department of Health and Human Services and that the waivers

1 under 42 CFR 433.68 for the assessment imposed by this  
2 Section, if necessary, have been granted by the Centers for  
3 Medicare and Medicaid Services of the U.S. Department of  
4 Health and Human Services.

5 (Source: P.A. 96-1530, eff. 2-16-11; 97-10, eff. 6-14-11;  
6 97-584, eff. 8-26-11.)

7 (305 ILCS 5/5B-4) (from Ch. 23, par. 5B-4)

8 Sec. 5B-4. Payment of assessment; penalty.

9 (a) The assessment imposed by Section 5B-2 shall be due  
10 and payable monthly, on the last State business day of the  
11 month for occupied bed days reported for the preceding third  
12 month prior to the month in which the tax is payable and due. A  
13 facility that has delayed payment due to the State's failure  
14 to reimburse for services rendered may request an extension on  
15 the due date for payment pursuant to subsection (b) and shall  
16 pay the assessment within 30 days of reimbursement by the  
17 Department. The Illinois Department may provide that county  
18 nursing homes directed and maintained pursuant to Section  
19 5-1005 of the Counties Code may meet their assessment  
20 obligation by certifying to the Illinois Department that  
21 county expenditures have been obligated for the operation of  
22 the county nursing home in an amount at least equal to the  
23 amount of the assessment.

24 (a-5) The Illinois Department shall provide for an  
25 electronic submission process for each long-term care facility

1 to report at a minimum the number of occupied bed days of the  
2 long-term care facility for the reporting period and other  
3 reasonable information the Illinois Department requires for  
4 the administration of its responsibilities under this Code.  
5 Beginning July 1, 2013, a separate electronic submission shall  
6 be completed for each long-term care facility in this State  
7 operated by a long-term care provider. The Illinois Department  
8 shall provide a self-reporting notice of the assessment form  
9 that the long-term care facility completes for the required  
10 period and submits with its assessment payment to the Illinois  
11 Department. To the extent practicable, the Department shall  
12 coordinate the assessment reporting requirements with other  
13 reporting required of long-term care facilities.

14 (b) The Illinois Department is authorized to establish  
15 delayed payment schedules for long-term care providers that  
16 are unable to make assessment payments when due under this  
17 Section due to financial difficulties, as determined by the  
18 Illinois Department. The Illinois Department may not deny a  
19 request for delay of payment of the assessment imposed under  
20 this Article if the long-term care provider has not been paid  
21 for services provided during the month on which the assessment  
22 is levied ~~or the Medicaid managed care organization has not~~  
23 ~~been paid by the State.~~

24 (c) If a long-term care provider fails to pay the full  
25 amount of an assessment payment when due (including any  
26 extensions granted under subsection (b)), there shall, unless

1 waived by the Illinois Department for reasonable cause, be  
2 added to the assessment imposed by Section 5B-2 a penalty  
3 assessment equal to the lesser of (i) 5% of the amount of the  
4 assessment payment not paid on or before the due date plus 5%  
5 of the portion thereof remaining unpaid on the last day of each  
6 month thereafter or (ii) 100% of the assessment payment amount  
7 not paid on or before the due date. For purposes of this  
8 subsection, payments will be credited first to unpaid  
9 assessment payment amounts (rather than to penalty or  
10 interest), beginning with the most delinquent assessment  
11 payments. Payment cycles of longer than 60 days shall be one  
12 factor the Director takes into account in granting a waiver  
13 under this Section.

14 (c-5) If a long-term care facility fails to file its  
15 assessment bill with payment, there shall, unless waived by  
16 the Illinois Department for reasonable cause, be added to the  
17 assessment due a penalty assessment equal to 25% of the  
18 assessment due. After July 1, 2013, no penalty shall be  
19 assessed under this Section if the Illinois Department does  
20 not provide a process for the electronic submission of the  
21 information required by subsection (a-5).

22 (d) Nothing in this amendatory Act of 1993 shall be  
23 construed to prevent the Illinois Department from collecting  
24 all amounts due under this Article pursuant to an assessment  
25 imposed before the effective date of this amendatory Act of  
26 1993.

1 (e) Nothing in this amendatory Act of the 96th General  
2 Assembly shall be construed to prevent the Illinois Department  
3 from collecting all amounts due under this Code pursuant to an  
4 assessment, tax, fee, or penalty imposed before the effective  
5 date of this amendatory Act of the 96th General Assembly.

6 (f) No installment of the assessment imposed by Section  
7 5B-2 shall be due and payable until after the Department  
8 notifies the long-term care providers, in writing, that the  
9 payment methodologies to long-term care providers required  
10 under Section 5-5.2 ~~5-5.4~~ of this Code have been approved by  
11 the Centers for Medicare and Medicaid Services of the U.S.  
12 Department of Health and Human Services and the waivers under  
13 42 CFR 433.68 for the assessment imposed by this Section, if  
14 necessary, have been granted by the Centers for Medicare and  
15 Medicaid Services of the U.S. Department of Health and Human  
16 Services. Upon notification to the Department of approval of  
17 the payment methodologies required under Section 5-5.2 ~~5-5.4~~  
18 of this Code and the waivers granted under 42 CFR 433.68, all  
19 installments otherwise due under Section 5B-4 prior to the  
20 date of notification shall be due and payable to the  
21 Department upon written direction from the Department within  
22 90 days after issuance by the Comptroller of the payments  
23 required under Section 5-5.2 ~~5-5.4~~ of this Code.

24 (Source: P.A. 100-501, eff. 6-1-18; 101-649, eff. 7-7-20.)

25 (305 ILCS 5/5B-5) (from Ch. 23, par. 5B-5)

1           Sec. 5B-5. Annual reporting; penalty; maintenance of  
2 records.

3           (a) After December 31 of each year, and on or before March  
4 31 of the succeeding year, every long-term care provider  
5 subject to assessment under this Article shall file a report  
6 with the Illinois Department. The report shall be in a form and  
7 manner prescribed by the Illinois Department and shall state  
8 the revenue received by the long-term care provider, reported  
9 in such categories as may be required by the Illinois  
10 Department, and other reasonable information the Illinois  
11 Department requires for the administration of its  
12 responsibilities under this Code.

13           (b) If a long-term care provider operates or maintains  
14 more than one long-term care facility in this State, the  
15 provider may not file a single return covering all those  
16 long-term care facilities, but shall file a separate return  
17 for each long-term care facility and shall compute and pay the  
18 assessment for each long-term care facility separately.

19           (c) Notwithstanding any other provision in this Article,  
20 in the case of a person who ceases to operate or maintain a  
21 long-term care facility in respect of which the person is  
22 subject to assessment under this Article as a long-term care  
23 provider, the person shall file a final, amended return with  
24 the Illinois Department not more than 90 days after the  
25 cessation reflecting the adjustment and shall pay with the  
26 final return the assessment for the year as so adjusted (to the

1 extent not previously paid). If a person fails to file a final  
2 amended return on a timely basis, there shall, unless waived  
3 by the Illinois Department for reasonable cause, be added to  
4 the assessment due a penalty assessment equal to 25% of the  
5 assessment due.

6 (d) Notwithstanding any other provision of this Article, a  
7 provider who commences operating or maintaining a long-term  
8 care facility that was under a prior ownership and remained  
9 licensed by the Department of Public Health shall notify the  
10 Illinois Department of any ~~the~~ change in ownership regardless  
11 of percentage, and shall be responsible to immediately pay any  
12 prior amounts owed by the facility. In addition, within 90  
13 days after the effective date of this amendatory Act of the  
14 102nd General Assembly, all providers operating or maintaining  
15 a long-term care facility shall notify the Illinois Department  
16 of all individual owners and any individuals or organizations  
17 that are part of a limited liability company with ownership of  
18 that facility and the percentage ownership of each owner. This  
19 ownership reporting requirement does not include individual  
20 shareholders in a publicly held corporation.

21 (e) The Department shall develop a procedure for sharing  
22 with a potential buyer of a facility information regarding  
23 outstanding assessments and penalties owed by that facility.

24 (f) In the case of a long-term care provider existing as a  
25 corporation or legal entity other than an individual, the  
26 return filed by it shall be signed by its president,

1 vice-president, secretary, or treasurer or by its properly  
2 authorized agent.

3 (g) If a long-term care provider fails to file its return  
4 on or before the due date of the return, there shall, unless  
5 waived by the Illinois Department for reasonable cause, be  
6 added to the assessment imposed by Section 5B-2 a penalty  
7 assessment equal to 25% of the assessment imposed for the  
8 year. After July 1, 2013, no penalty shall be assessed if the  
9 Illinois Department has not established a process for the  
10 electronic submission of information.

11 (h) Every long-term care provider subject to assessment  
12 under this Article shall keep records and books that will  
13 permit the determination of occupied bed days on a calendar  
14 year basis. All such books and records shall be kept in the  
15 English language and shall, at all times during business hours  
16 of the day, be subject to inspection by the Illinois  
17 Department or its duly authorized agents and employees.

18 (i) The Illinois Department shall establish a process for  
19 long-term care providers to electronically submit all  
20 information required by this Section no later than July 1,  
21 2013.

22 (Source: P.A. 96-1530, eff. 2-16-11; 97-403, eff. 1-1-12;  
23 97-813, eff. 7-13-12.)

24 (305 ILCS 5/5B-8) (from Ch. 23, par. 5B-8)

25 Sec. 5B-8. Long-Term Care Provider Fund.



1 (a) There is created in the State Treasury the Long-Term  
2 Care Provider Fund. Interest earned by the Fund shall be  
3 credited to the Fund. The Fund shall not be used to replace any  
4 moneys appropriated to the Medicaid program by the General  
5 Assembly.

6 (b) The Fund is created for the purpose of receiving and  
7 disbursing moneys in accordance with this Article.  
8 Disbursements from the Fund shall be made only as follows:

9 (1) For payments to nursing facilities, including  
10 county nursing facilities but excluding State-operated  
11 facilities, under Title XIX of the Social Security Act and  
12 Article V of this Code.

13 (1.5) For payments to managed care organizations as  
14 defined in Section 5-30.1 of this Code.

15 (2) For the reimbursement of moneys collected by the  
16 Illinois Department through error or mistake.

17 (3) For payment of administrative expenses incurred by  
18 the Illinois Department or its agent in performing the  
19 activities authorized by this Article.

20 (3.5) For reimbursement of expenses incurred by  
21 long-term care facilities, and payment of administrative  
22 expenses incurred by the Department of Public Health, in  
23 relation to the conduct and analysis of background checks  
24 for identified offenders under the Nursing Home Care Act.

25 (4) For payments of any amounts that are reimbursable  
26 to the federal government for payments from this Fund that

1 are required to be paid by State warrant.

2 (5) For making transfers to the General Obligation  
3 Bond Retirement and Interest Fund, as those transfers are  
4 authorized in the proceedings authorizing debt under the  
5 Short Term Borrowing Act, but transfers made under this  
6 paragraph (5) shall not exceed the principal amount of  
7 debt issued in anticipation of the receipt by the State of  
8 moneys to be deposited into the Fund.

9 (6) For making transfers, at the direction of the  
10 Director of the Governor's Office of Management and Budget  
11 during each fiscal year beginning on or after July 1,  
12 2011, to other State funds in an annual amount of  
13 \$20,000,000 of the tax collected pursuant to this Article  
14 for the purpose of enforcement of nursing home standards,  
15 support of the ombudsman program, and efforts to expand  
16 home and community-based services. No transfer under this  
17 paragraph shall occur until (i) the payment methodologies  
18 created by Public Act 96-1530 under Section 5-5.4 of this  
19 Code have been approved by the Centers for Medicare and  
20 Medicaid Services of the U.S. Department of Health and  
21 Human Services and (ii) the assessment imposed by Section  
22 5B-2 of this Code is determined to be a permissible tax  
23 under Title XIX of the Social Security Act.

24 Disbursements from the Fund, other than transfers made  
25 pursuant to paragraphs (5) and (6) of this subsection, shall  
26 be by warrants drawn by the State Comptroller upon receipt of

1 vouchers duly executed and certified by the Illinois  
2 Department.

3 (c) The Fund shall consist of the following:

4 (1) All moneys collected or received by the Illinois  
5 Department from the long-term care provider assessment  
6 imposed by this Article.

7 (2) All federal matching funds received by the  
8 Illinois Department as a result of expenditures made from  
9 the Fund ~~by the Illinois Department that are attributable~~  
10 ~~to moneys deposited in the Fund.~~

11 (3) Any interest or penalty levied in conjunction with  
12 the administration of this Article.

13 (4) (Blank).

14 (5) All other monies received for the Fund from any  
15 other source, including interest earned thereon.

16 (Source: P.A. 96-1530, eff. 2-16-11; 97-584, eff. 8-26-11.)

17 (305 ILCS 5/5E-10)

18 Sec. 5E-10. Fee. Through December 31, 2021 or upon federal  
19 approval by the Centers for Medicare and Medicaid Services of  
20 the long-term care provider assessment described in subsection  
21 (a-1) of Section 5B-2 of this Code, whichever is later, every  
22 ~~Every~~ nursing home provider shall pay to the Illinois  
23 Department, on or before September 10, December 10, March 10,  
24 and June 10, a fee in the amount of \$1.50 for each licensed  
25 nursing bed day for the calendar quarter in which the payment

1 is due. This fee shall not be billed or passed on to any  
2 resident of a nursing home operated by the nursing home  
3 provider. All fees received by the Illinois Department under  
4 this Section shall be deposited into the Long-Term Care  
5 Provider Fund. This Section 5E-10 is repealed on December 31,  
6 2023.

7 (Source: P.A. 88-88; 89-21, eff. 7-1-95.)

8 (305 ILCS 5/5E-20 new)

9 Sec. 5E-20. Repealer. This Article 5E is repealed on July  
10 1, 2024.

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

1	INDEX	
2	Statutes amended in order of appearance	
3	5 ILCS 100/5-45.21 new	
4	225 ILCS 510/3	from Ch. 111, par. 953
5	225 ILCS 510/14	from Ch. 111, par. 964
6	305 ILCS 5/5-5.2	from Ch. 23, par. 5-5.2
7	305 ILCS 5/5B-2	from Ch. 23, par. 5B-2
8	305 ILCS 5/5B-4	from Ch. 23, par. 5B-4
9	305 ILCS 5/5B-5	from Ch. 23, par. 5B-5
10	305 ILCS 5/5B-8	from Ch. 23, par. 5B-8
11	305 ILCS 5/5E-10	
12	305 ILCS 5/5E-20 new	