**Rep. Camille Y. Lilly**

# Filed: 1/10/2021



AMENDMENT TO HOUSE BILL 5548

AMENDMENT NO. _____. Amend House Bill 5548 by replacing everything after the enacting clause with the following:

"Title I. General Provisions

Article 1.

Section 1-1. This Act may be referred to as the Illinois Health Care and Human Service Reform Act.

Section 1-5. Findings.

"We, the People of the State of Illinois - grateful to Almighty God for the civil, political and religious liberty which He has permitted us to enjoy and seeking His blessing upon our endeavors - in order to provide for the health, safety and welfare of the people; maintain a representative and orderly government; eliminate poverty and inequality; assure

legal, social and economic justice; provide opportunity for the fullest development of the individual; insure domestic tranquility; provide for the common defense; and secure the blessings of freedom and liberty to ourselves and our posterity - do ordain and establish this Constitution for the State of Illinois."

The Illinois Legislative Black Caucus finds that, in order to improve the health outcomes of Black residents in the State of Illinois, it is essential to dramatically reform the State's health and human service system. For over 3 decades. multiple health studies have found that health inequities at their very core are due to racism. As early as 1998 research demonstrated that Black Americans received less health care than white Americans because doctors treated patients differently on the basis of race. Yet, Illinois' health and human service system disappointingly continues to perpetuate health disparities among Black Illinoisans of all ages, genders, and socioeconomic status.

In July 2020, Trinity Health announced its plans to close Mercy Hospital, an essential resource serving the Chicago South Side's predominantly Black residents. Trinity Health argued that this closure would have no impact on health access but failed to understand the community's needs. Closure of Mercy Hospital would only serve to create a health access desert and exacerbate existing health disparities. On December 15, 2020, after hearing from community members and advocates, the Health

Facilities and Services Review Board unanimously voted to deny closure efforts, yet Trinity still seeks to cease Mercy's operations.

Prior to COVID-19, much of the social and political attention surrounding the nationwide opioid epidemic focused on the increase in overdose deaths among white, middle-class, suburban and rural users; the impact of the epidemic in Black communities was largely unrecognized. Research has shown rates of opioid use at the national scale are higher for whites than they are for Blacks, yet rates of opioid deaths are higher among Blacks (43%) than whites (22%). The COVID-19 pandemic will likely exacerbate this situation due to job loss, stay-at-home orders, and ongoing mitigation efforts creating a lack of physical access to addiction support and harm reduction groups.

In 2018, the Illinois Department of Public Health reported that Black women were about 6 times as likely to die from a pregnancy-related cause as white women. Of those, 72% of pregnancy-related deaths and 93% of violent pregnancy-associated deaths were deemed preventable. Between 2016 and 2017, Black women had the highest rate of severe maternal morbidity with a rate of 101.5 per 10,000 deliveries, which is almost 3 times as high as the rate for white women.

In the City of Chicago, African American and Latinx populations are suffering from higher rates of AIDS/HIV compared to the general population. Recent data places HIV as

one of the top 5 leading causes of death in African American women between the ages of 35 to 44 and the seventh ranking cause in African American women between the ages of 20 to 34. Among the Latinx population, nearly 20% with HIV exclusively depend on indigenous-led and staffed organizations for services.

Cardiovascular disease (CVD) accounts for more deaths in Illinois than any other cause of death, according to the Illinois Department of Public Health; CVD is the leading cause of death among Black residents. According to the Kaiser Family Foundation (KFF), for every 100,000 people, 224 Black Illinoisans die of CVD compared to 158 white Illinoisans. Cancer, the second leading cause of death in Illinois, too is pervasive among African Americans. In 2019, an estimated 606,880 Americans, or 1,660 people a day, died of cancer; the American Cancer Society estimated 24,410 deaths occurred in Illinois. KFF estimates that, out of every 100,000 people, 191 Black Illinoisans die of cancer compared to 152 white Illinoisans.

Black Americans suffer at much higher rates from chronic diseases, including diabetes, hypertension, heart disease, asthma, and many cancers. Utilizing community health workers in patient education and chronic disease management is needed to close these health disparities. Studies have shown that diabetes patients in the care of a community health worker demonstrate improved knowledge and lifestyle and

self-management behaviors, as well as decreases in the use of the emergency department. A study of asthma control among black adolescents concluded that asthma control was reduced by 35% among adolescents working with community health workers, resulting in a savings of $5.58 per dollar spent on the intervention. A study of the return on investment for community health workers employed in Colorado showed that, after a 9-month period, patients working with community health workers had an increased number of primary care visits and a decrease in urgent and inpatient care. Utilization of community health workers led to a $2.38 return on investment for every dollar invested in community health workers.

Adverse childhood experiences (ACEs) are traumatic experiences occurring during childhood that have been found to have a profound effect on a child's developing brain structure and body which may result in poor health during a person's adulthood. ACEs studies have found a strong correlation between the number of ACEs and a person's risk for disease and negative health behaviors, including suicide, depression, cancer, stroke, ischemic heart disease, diabetes, autoimmune disease, smoking, substance abuse, interpersonal violence, obesity, unplanned pregnancies, lower educational achievement, workplace absenteeism, and lower wages. Data also shows that approximately 20% of African American and Hispanic adults in Illinois reported 4 or more ACEs, compared to 13% of non-Hispanic whites. Long-standing ACE interventions include

tools such as trauma-informed care. Trauma-informed care has been promoted and established in communities across the country on a bipartisan basis, including in the states of California, Florida, Massachusetts, Missouri, Oregon, Pennsylvania, Washington, and Wisconsin. Several federal agencies have integrated trauma-informed approaches in their programs and grants which should be leveraged by the State.

According to a 2019 Rush University report, a Black person's life expectancy on average is less when compared to a white person's life expectancy. For instance, when comparing life expectancy in Chicago's Austin neighborhood to the Chicago Loop, there is a difference of 11 years between Black life expectancy (71 years) and white life expectancy (82 years).

In a 2015 literature review of implicit racial and ethnic bias among medical professionals, it was concluded that there is a moderate level of implicit bias in most medical professionals. Further, the literature review showed that implicit bias has negative consequences for patients, including strained patient relationships and negative health outcomes. It is critical for medical professionals to be aware of implicit racial and ethnic bias and work to eliminate bias through training.

In the field of medicine, a historically racist profession, Black medical professionals have commonly been ostracized. In 1934, Dr. Roland B. Scott was the first African American to pass the pediatric board exam, yet when he applied for

membership with the American Academy of Pediatrics he was rejected multiple times. Few medical organizations have confronted the roles they played in blocking opportunities for Black advancement in the medical profession until the formal apologies of the American Medical Association in 2008. For decades, organizations like the AMA predicated their membership on joining a local state medical society, several of which excluded Black physicians.

In 2010, the General Assembly, in partnership with Treatment Alternatives for Safe Communities, published the Disproportionate Justice Impact Study. The study examined the impact of Illinois drug laws on racial and ethnic groups and the resulting over-representation of racial and ethic minority groups in the Illinois criminal justice system. Unsurprisingly and disappointingly, the study confirmed decades long injustices, such as nonwhites being arrested at a higher rate than whites relative to their representation in the general population throughout Illinois.

All together, the above mentioned only begins to capture a part of a larger system of racial injustices and inequities. The General Assembly and the people of Illinois are urged to recognize while racism is a core fault of the current health and human service system, that it is a pervasive disease affecting a multiplitude of institutions which truly drive systematic health inequities: education, child care, criminal justice, affordable housing, environmental justice, and job

security and so forth. For persons to live up to their full human potential, their rights to quality of life, health care, a quality job, a fair wage, housing, and education must not be inhibited.

Therefore, the Illinois Legislative Black Caucus, as informed by the Senate's Health and Human Service Pillar subject matter hearings, seeks to remedy a fraction of a much larger broken system by addressing access to health care, hospital closures, managed care organization reform, community health worker certification, maternal and infant mortality, mental and substance abuse treatment, hospital reform, and medical implicit bias in the Illinois Health Care and Human Service Reform Act. This Act shall achieve needed change through the use of, but not limited to, the Medicaid Managed Care Oversight Commission, the Health and Human Services Task Force, and a hospital closure moratorium, in order to address Illinois' long-standing health inequities.

## Title II. Community Health Workers

### Article 5.

Section 5-1. Short title. This Article may be cited as the Community Health Worker Certification and Reimbursement Act. References in this Article to "this Act" mean this Article.

Section 5-5. Definition. In this Act, "community health worker" means a frontline public health worker who is a trusted member or has an unusually close understanding of the community served. This trusting relationship enables the community health worker to serve as a liaison, link, and intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, including outreach, community education, informal counseling, social support, and advocacy. A community health worker shall have the following core competencies:

(1) communication;

(2) interpersonal skills and relationship building;

(3) service coordination and navigation skills;

(4) capacity-building;

(5) advocacy;

(6) presentation and facilitation skills;

(7) organizational skills; cultural competency;

(8) public health knowledge;

(9) understanding of health systems and basic diseases;

(10) behavioral health issues; and

(11) field experience.

Nothing in this definition shall be construed to authorize

a community health worker to provide direct care or treatment to any person or to perform any act or service for which a license issued by a professional licensing board is required.

Section 5-10. Community health worker training.

(a) Community health workers shall be provided with multi-tiered academic and community-based training opportunities that lead to the mastery of community health worker core competencies.

(b) For academic-based training programs, the Department of Public Health shall collaborate with the Illinois State Board of Education, the Illinois Community College Board, and the Illinois Board of Higher Education to adopt a process to certify academic-based training programs that students can attend to obtain individual community health worker certification. Certified training programs shall reflect the approved core competencies and roles for community health workers.

(c) For community-based training programs, the Department of Public Health shall collaborate with a statewide association representing community health workers to adopt a process to certify community-based programs that students can attend to obtain individual community health worker certification.

(d) Community health workers may need to undergo additional training, including, but not limited to, asthma, diabetes, maternal child health, behavioral health, and social

determinants of health training. Multi-tiered training approaches shall provide opportunities that build on each other and prepare community health workers for career pathways both within the community health worker profession and within allied professions.

Section 5-15. Illinois Community Health Worker Certification Board.

(a) There is created within the Department of Public Health, in shared leadership with a statewide association representing community health workers, the Illinois Community Health Worker Certification Board. The Board shall serve as the regulatory body that develops and has oversight of initial community health workers certification and certification renewals for both individuals and academic and community-based training programs

(b) A representative from the Department of Public Health, the Department of Financial and Professional Regulation and the Department of Healthcare and Family Services shall serve on the Board. At least one full-time professional shall be assigned to staff the Board with additional administrative support available as needed. The Board shall have balanced representation from the community health worker workforce, community health worker employers, community health worker training and educational organizations, and other engaged stakeholders.

(c) The Board shall propose a certification process for and be authorized to approve training from community-based organizations, in conjunction with a statewide organization representing community health workers, and academic institutions, in consultation with the Illinois State Board of Education, the Illinois Community College Board and the Illinois Board of Higher Education. The Board shall base training approval on core competencies, best practices, and affordability. In addition, the Board shall maintain a registry of certification records for individually certified community health workers.

(d) All training programs that are deemed certifiable by the Board shall go through a renewal process, which will be determined by the Board once established. The Board shall establish criteria to grandfather in any community health workers who were practicing prior to the establishment of a certification program.

Section 5-20. Reimbursement. Community health worker services shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance. The Department of Healthcare and Family Services shall develop services, including but not limited to, care coordination and diagnostic-related patient education services, for which community health workers will be eligible for reimbursement and shall submit a State Plan Amendment (SPA) to the Centers for

Medicare and Medicaid Services (CMS) to amend the agreement between Illinois and the Federal government to include community health workers as practitioners under Medicaid. Certification shall not be required for reimbursement. In addition, the Department of Healthcare and Family Services shall amend its contracts with managed care entities to allow managed care entities to employ community health workers or subcontract with community-based organizations that employ community health workers.

Title III. Hospital Reform

Article 10.

Section 10-5. The University of Illinois Hospital Act is amended by adding Section 12 as follows:

(110 ILCS 330/12 new)

Sec. 12. Credentials and certificates. The University of Illinois Hospital shall require an intern, resident, or physician who provides medical services at the University of Illinois Hospital to have proper credentials and any required certificates for ongoing training at the time the intern, resident, or physician renews his or her license.

Section 10-10. The Hospital Licensing Act is amended by

adding Section 10.12 as follows:

(210 ILCS 85/10.12 new)

Sec. 10.12. Credentials and certificates. A hospital licensed under this Act shall require an intern, resident, or physician who provides medical services at the hospital to have proper credentials and any required certificates for ongoing training at the time the intern, resident, or physician renews his or her license.

Section 10-15. The Hospital Report Card Act is amended by changing Section 25 as follows:

(210 ILCS 86/25)

Sec. 25. Hospital reports.

(a) Individual hospitals shall prepare a quarterly report including all of the following:

(1) Nursing hours per patient day, average daily census, and average daily hours worked for each clinical service area.

(2) Infection-related measures for the facility for the specific clinical procedures and devices determined by the Department by rule under 2 or more of the following categories:

(A) Surgical procedure outcome measures.

(B) Surgical procedure infection control process

measures.

(C) Outcome or process measures related to ventilator-associated pneumonia.

(D) Central vascular catheter-related bloodstream infection rates in designated critical care units.

(3) Information required under paragraph (4) of Section 2310-312 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois.

(4) Additional infection measures mandated by the Centers for Medicare and Medicaid Services that are reported by hospitals to the Centers for Disease Control and Prevention's National Healthcare Safety Network surveillance system, or its successor, and deemed relevant to patient safety by the Department.

(5) Each instance of preterm birth and infant mortality within the reporting period, including the racial and ethnic information of the mothers of those infants.

(6) Each instance of maternal mortality within the reporting period, including the racial and ethnic information of those mothers.

(7) The number of female patients who have died within the reporting period.

(8) The number of female patients who have died of a preventable cause within the reporting period and the number of those preventable deaths that the hospital has

otherwise reported within the reporting period.

(9) The number of physicians, as that term is defined in the Medical Practice Act of 1987, required by the hospital to undergo any amount or type of retraining during the reporting period.

The infection-related measures developed by the Department shall be based upon measures and methods developed by the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, the Joint Commission on Accreditation of Healthcare Organizations, or the National Quality Forum. The Department may align the infection-related measures with the measures and methods developed by the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, the Joint Commission on Accreditation of Healthcare Organizations, and the National Quality Forum by adding reporting measures based on national health care strategies and measures deemed scientifically reliable and valid for public reporting. The Department shall receive approval from the State Board of Health to retire measures deemed no longer scientifically valid or valuable for informing quality improvement or infection prevention efforts. The Department shall notify the Chairs and Minority Spokespersons of the House Human Services Committee and the Senate Public Health Committee of its intent to have the State Board of Health take action to retire measures no

later than 7 business days before the meeting of the State Board of Health.

The Department shall include interpretive guidelines for infection-related indicators and, when available, shall include relevant benchmark information published by national organizations.

The Department shall collect the information reported under paragraphs (5) and (6) and shall use it to illustrate the disparity of those occurrences across different racial and ethnic groups.

(b) Individual hospitals shall prepare annual reports including vacancy and turnover rates for licensed nurses per clinical service area.

(c) None of the information the Department discloses to the public may be made available in any form or fashion unless the information has been reviewed, adjusted, and validated according to the following process:

(1) The Department shall organize an advisory committee, including representatives from the Department, public and private hospitals, direct care nursing staff, physicians, academic researchers, consumers, health insurance companies, organized labor, and organizations representing hospitals and physicians. The advisory committee must be meaningfully involved in the development of all aspects of the Department's methodology for collecting, analyzing, and disclosing the information

collected under this Act, including collection methods, formatting, and methods and means for release and dissemination.

(2) The entire methodology for collecting and analyzing the data shall be disclosed to all relevant organizations and to all hospitals that are the subject of any information to be made available to the public before any public disclosure of such information.

(3) Data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability before any information is made available to the public.

(4) The limitations of the data sources and analytic methodologies used to develop comparative hospital information shall be clearly identified and acknowledged, including but not limited to the appropriate and inappropriate uses of the data.

(5) To the greatest extent possible, comparative hospital information initiatives shall use standard-based norms derived from widely accepted provider-developed practice guidelines.

(6) Comparative hospital information and other information that the Department has compiled regarding hospitals shall be shared with the hospitals under review prior to public dissemination of such information and these hospitals have 30 days to make corrections and to add

helpful explanatory comments about the information before the publication.

(7) Comparisons among hospitals shall adjust for patient case mix and other relevant risk factors and control for provider peer groups, when appropriate.

(8) Effective safeguards to protect against the unauthorized use or disclosure of hospital information shall be developed and implemented.

(9) Effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective hospital data shall be developed and implemented.

(10) The quality and accuracy of hospital information reported under this Act and its data collection, analysis, and dissemination methodologies shall be evaluated regularly.

(11) Only the most basic identifying information from mandatory reports shall be used, and information identifying a patient, employee, or licensed professional shall not be released. None of the information the Department discloses to the public under this Act may be used to establish a standard of care in a private civil action.

(d) Quarterly reports shall be submitted, in a format set forth in rules adopted by the Department, to the Department by April 30, July 31, October 31, and January 31 each year for the

previous quarter. Data in quarterly reports must cover a period ending not earlier than one month prior to submission of the report. Annual reports shall be submitted by December 31 in a format set forth in rules adopted by the Department to the Department. All reports shall be made available to the public on-site and through the Department.

(e) If the hospital is a division or subsidiary of another entity that owns or operates other hospitals or related organizations, the annual public disclosure report shall be for the specific division or subsidiary and not for the other entity.

(f) The Department shall disclose information under this Section in accordance with provisions for inspection and copying of public records required by the Freedom of Information Act provided that such information satisfies the provisions of subsection (c) of this Section.

(g) Notwithstanding any other provision of law, under no circumstances shall the Department disclose information obtained from a hospital that is confidential under Part 21 of Article VIII of the Code of Civil Procedure.

(h) No hospital report or Department disclosure may contain information identifying a patient, employee, or licensed professional.

(Source: P.A. 101-446, eff. 8-23-19.)

Article 15.

Section 15-5. The Hospital Licensing Act is amended by adding Section 6.30 as follows:

(210 ILCS 85/6.30 new)

Sec. 6.30. Posting charity care policy, financial counselor. A hospital that receives a property tax exemption under Section 15-86 of the Property Tax Code must post the hospital's charity care policy and the contact information of a financial counselor in a reasonably viewable area in the hospital's emergency room.

Article 20.

Section 20-5. The University of Illinois Hospital Act is amended by adding Section 8d as follows:

(110 ILCS 330/8d new)

Sec. 8d. N95 masks. The University of Illinois Hospital shall provide N95 masks to all physicians licensed under the Medical Practice Act of 1987 and registered nurses and advanced practice registered nurses licensed under the Nurse Licensing Act if the physician, registered nurse, or advanced practice registered nurse is employed by or providing services for another employer at the University of Illinois Hospital.

Section 20-10. The Hospital Licensing Act is amended by adding Section 6.28 as follows:

(210 ILCS 85/6.28 new)

Sec. 6.28. N95 masks. A hospital licensed under this Act shall provide N95 masks to all physicians licensed under the Medical Practice Act of 1987 and registered nurses and advanced practice registered nurses licensed under the Nurse Licensing Act if the physician, registered nurse, or advanced practice registered nurse is employed by or providing services for another employer at the hospital.

Article 25.

Section 25-5. The University of Illinois Hospital Act is amended by adding Section 11 as follows:

(110 ILCS 330/11 new)

Sec. 11. Demographic data; release of individuals with symptoms of COVID-19. The University of Illinois Hospital shall report to the Department of Public Health the demographic data of individuals who have symptoms of COVID-19 and are released from, not admitted to, the University of Illinois Hospital.

Section 25-10. The Hospital Licensing Act is amended by adding Section 6.31 as follows:

(210 ILCS 85/6.31 new)

Sec. 6.31. Demographic data; release of individuals with symptoms of COVID-19. A hospital licensed under this Act shall report to the Department the demographic data of individuals who have symptoms of COVID-19 and are released from, not admitted to, the hospital.

Article 35.

Section 35-5. The Illinois Public Aid Code is amended by changing Section 5-5.05 as follows:

(305 ILCS 5/5-5.05)

Sec. 5-5.05. Hospitals; psychiatric services.

(a) On and after July 1, 2008, the inpatient, per diem rate to be paid to a hospital for inpatient psychiatric services shall be $363.77.

(b) For purposes of this Section, "hospital" means the following:

(1) Advocate Christ Hospital, Oak Lawn, Illinois.

(2) Barnes-Jewish Hospital, St. Louis, Missouri.

(3) BroMenn Healthcare, Bloomington, Illinois.

(4) Jackson Park Hospital, Chicago, Illinois.

(5) Katherine Shaw Bethea Hospital, Dixon, Illinois.

(6) Lawrence County Memorial Hospital, Lawrenceville,

Illinois.

(7) Advocate Lutheran General Hospital, Park Ridge, Illinois.

(8) Mercy Hospital and Medical Center, Chicago, Illinois.

(9) Methodist Medical Center of Illinois, Peoria, Illinois.

(10) Provena United Samaritans Medical Center, Danville, Illinois.

(11) Rockford Memorial Hospital, Rockford, Illinois.

(12) Sarah Bush Lincoln Health Center, Mattoon, Illinois.

(13) Provena Covenant Medical Center, Urbana, Illinois.

(14) Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois.

(15) Mt. Sinai Hospital, Chicago, Illinois.

(16) Gateway Regional Medical Center, Granite City, Illinois.

(17) St. Mary of Nazareth Hospital, Chicago, Illinois.

(18) Provena St. Mary's Hospital, Kankakee, Illinois.

(19) St. Mary's Hospital, Decatur, Illinois.

(20) Memorial Hospital, Belleville, Illinois.

(21) Swedish Covenant Hospital, Chicago, Illinois.

(22) Trinity Medical Center, Rock Island, Illinois.

(23) St. Elizabeth Hospital, Chicago, Illinois.

(24) Richland Memorial Hospital, Olney, Illinois.

(25) St. Elizabeth's Hospital, Belleville, Illinois.

(26) Samaritan Health System, Clinton, Iowa.

(27) St. John's Hospital, Springfield, Illinois.

(28) St. Mary's Hospital, Centralia, Illinois.

(29) Loretto Hospital, Chicago, Illinois.

(30) Kenneth Hall Regional Hospital, East St. Louis, Illinois.

(31) Hinsdale Hospital, Hinsdale, Illinois.

(32) Pekin Hospital, Pekin, Illinois.

(33) University of Chicago Medical Center, Chicago, Illinois.

(34) St. Anthony's Health Center, Alton, Illinois.

(35) OSF St. Francis Medical Center, Peoria, Illinois.

(36) Memorial Medical Center, Springfield, Illinois.

(37) A hospital with a distinct part unit for psychiatric services that begins operating on or after July 1, 2008.

For purposes of this Section, "inpatient psychiatric services" means those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder.

(b-5) Notwithstanding any other provision of this Section, the inpatient, per diem rate to be paid to all community safety-net hospitals for inpatient psychiatric services on and after January 1, 2021 shall be at least $630.

(c) No rules shall be promulgated to implement this Section. For purposes of this Section, "rules" is given the meaning contained in Section 1-70 of the Illinois Administrative Procedure Act.

(d) This Section shall not be in effect during any period of time that the State has in place a fully operational hospital assessment plan that has been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(e) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(Source: P.A. 97-689, eff. 6-14-12.)

## Title IV. Medical Implicit Bias

### Article 45.

Section 45-1. Findings. The General Assembly finds and declares all of the following:

(a) Implicit bias, meaning the attitudes or internalized stereotypes that affect our perceptions, actions, and decisions in an unconscious manner, exists and often contributes to unequal treatment of people based on race,

ethnicity, gender identity, sexual orientation, age, disability, and other characteristics.

(b) Implicit bias contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licensees.

(c) African American women are 3 to 4 times more likely than white women to die from pregnancy-related causes nationwide. African American patients often are prescribed less pain medication than white patients who present the same complaints. African American patients with signs of heart problems are not referred for advanced cardiovascular procedures as often as white patients with the same symptoms.

(d) Implicit gender bias also impacts treatment decisions and outcomes. Women are less likely to survive a heart attack when they are treated by a male physician and surgeon. LGBTQ and gender-nonconforming patients are less likely to seek timely medical care because they experience disrespect and discrimination from health care staff, with one out of 5 transgender patients nationwide reporting that they were outright denied medical care due to bias.

(e) The General Assembly intends to reduce disparate outcomes and ensure that all patients receive fair treatment and quality health care.

Section 45-5. The Medical Practice Act of 1987 is amended by changing Section 20 as follows:

(225 ILCS 60/20) (from Ch. 111, par. 4400-20)

(Section scheduled to be repealed on January 1, 2022)

Sec. 20. Continuing education.

(a) The Department shall promulgate rules of continuing education for persons licensed under this Act that require an average of 50 hours of continuing education per license year. These rules shall be consistent with requirements of relevant professional associations, specialty societies, or boards. The rules shall also address variances in part or in whole for good cause, including, but not limited to, temporary illness or hardship. In establishing these rules, the Department shall consider educational requirements for medical staffs, requirements for specialty society board certification or for continuing education requirements as a condition of membership in societies representing the 2 categories of licensee under this Act. These rules shall assure that licensees are given the opportunity to participate in those programs sponsored by or through their professional associations or hospitals which are relevant to their practice.

(b) Except as otherwise provided in this subsection, the rules adopted under this Section shall require that, on and after January 1, 2022, all continuing education courses for persons licensed under this Act contain curriculum that includes the understanding of implicit bias. Beginning January 1, 2023, continuing education providers shall ensure

compliance with this Section. Beginning January 1, 2023, the Department shall audit continuing education providers at least once every 5 years to ensure adherence to regulatory requirements and shall withhold or rescind approval from any provider that is in violation of the requirements of this subsection.

A continuing education course dedicated solely to research or other issues that does not include a direct patient care component is not required to contain curriculum that includes implicit bias in the practice of medicine.

To satisfy the requirements of this subsection, continuing education courses shall address at least one of the following:

(1) examples of how implicit bias affects perceptions and treatment decisions, leading to disparities in health outcomes; or

(2) strategies to address how unintended biases in decision making may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

(c) Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.

(Source: P.A. 97-622, eff. 11-23-11.)

Section 45-10. The Nurse Practice Act is amended by changing Sections 55-35, 60-40, and 65-60 as follows:

(225 ILCS 65/55-35)

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

Sec. 55-35. Continuing education for LPN licensees.

(a) The Department may adopt rules of continuing education for licensed practical nurses that require 20 hours of continuing education per 2-year license renewal cycle. The rules shall address variances in part or in whole for good cause, including without limitation illness or hardship. The continuing education rules must ensure that licensees are given the opportunity to participate in programs sponsored by or through their State or national professional associations, hospitals, or other providers of continuing education.

(b) For license renewals occurring on or after January 1, 2022, all licensed practical nurses must complete at least one hour of implicit bias training per 2-year license renewal cycle. The Department may adopt rules for the implementation of this subsection.

(c) Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.

(Source: P.A. 95-639, eff. 10-5-07.)

(225 ILCS 65/60-40)

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

Sec. 60-40. Continuing education for RN licensees.

(a) The Department may adopt rules of continuing education for registered professional nurses licensed under this Act that require 20 hours of continuing education per 2-year license renewal cycle. The rules shall address variances in part or in whole for good cause, including without limitation illness or hardship. The continuing education rules must ensure that licensees are given the opportunity to participate in programs sponsored by or through their State or national professional associations, hospitals, or other providers of continuing education.

(b) For license renewals occurring on or after January 1, 2022, all registered professional nurses must complete at least one hour of implicit bias training per 2-year license renewal cycle. The Department may adopt rules for the implementation of this subsection.

(c) Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.

(Source: P.A. 95-639, eff. 10-5-07.)

(225 ILCS 65/65-60) (was 225 ILCS 65/15-45)

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

Sec. 65-60. Continuing education.

(a) The Department shall adopt rules of continuing

education for persons licensed under this Article as advanced practice registered nurses that require 80 hours of continuing education per 2-year license renewal cycle. Completion of the 80 hours of continuing education shall be deemed to satisfy the continuing education requirements for renewal of a registered professional nurse license as required by this Act.

The 80 hours of continuing education required under this Section shall be completed as follows:

(1) A minimum of 50 hours of the continuing education shall be obtained in continuing education programs as determined by rule that shall include no less than 20 hours of pharmacotherapeutics, including 10 hours of opioid prescribing or substance abuse education. Continuing education programs may be conducted or endorsed by educational institutions, hospitals, specialist associations, facilities, or other organizations approved to offer continuing education under this Act or rules and shall be in the advanced practice registered nurse's specialty.

(2) A maximum of 30 hours of credit may be obtained by presentations in the advanced practice registered nurse's clinical specialty, evidence-based practice, or quality improvement projects, publications, research projects, or preceptor hours as determined by rule.

The rules adopted regarding continuing education shall be consistent to the extent possible with requirements of relevant

national certifying bodies or State or national professional associations.

(b) The rules shall not be inconsistent with requirements of relevant national certifying bodies or State or national professional associations. The rules shall also address variances in part or in whole for good cause, including but not limited to illness or hardship. The continuing education rules shall assure that licensees are given the opportunity to participate in programs sponsored by or through their State or national professional associations, hospitals, or other providers of continuing education.

(c) For license renewals occurring on or after January 1, 2022, all advanced practice registered nurses must complete at least one hour of implicit bias training per 2-year license renewal cycle. The Department may adopt rules for the implementation of this subsection.

(d) Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.

(Source: P.A. 100-513, eff. 1-1-18.)

Section 45-15. The Physician Assistant Practice Act of 1987 is amended by changing Section 11.5 as follows:

(225 ILCS 95/11.5)

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

Sec. 11.5. Continuing education.

(a) The Department shall adopt rules for continuing education for persons licensed under this Act that require 50 hours of continuing education per 2-year license renewal cycle. Completion of the 50 hours of continuing education shall be deemed to satisfy the continuing education requirements for renewal of a physician assistant license as required by this Act. The rules shall not be inconsistent with requirements of relevant national certifying bodies or State or national professional associations. The rules shall also address variances in part or in whole for good cause, including, but not limited to, illness or hardship. The continuing education rules shall ensure that licensees are given the opportunity to participate in programs sponsored by or through their State or national professional associations, hospitals, or other providers of continuing education.

(b) Except as otherwise provided in this subsection, the rules adopted under this Section shall require that, on and after January 1, 2022, all continuing education courses for persons licensed under this Act contain curriculum that includes the understanding of implicit bias. Beginning January 1, 2023, continuing education providers shall ensure compliance with this Section. Beginning January 1, 2023, the Department shall audit continuing education providers at least once every 5 years to ensure adherence to regulatory requirements and shall withhold or rescind approval from any

provider that is in violation of the regulatory requirements.

A continuing education course dedicated solely to research or other issues that does not include a direct patient care component is not required to contain curriculum that includes implicit bias in the practice of medicine.

To satisfy the requirements of subsection (a) of this Section, continuing education courses shall address at least one of the following:

(1) examples of how implicit bias affects perceptions and treatment decisions, leading to disparities in health outcomes; or

(2) strategies to address how unintended biases in decision making may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

(c) Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.

(Source: P.A. 100-453, eff. 8-25-17.)

Title V. Substance Abuse and Mental Health Treatment

Article 50.

Section 50-5. The Illinois Controlled Substances Act is amended by changing Section 414 as follows:

(720 ILCS 570/414)

Sec. 414. Overdose; limited immunity ~~from prosecution~~.

(a) For the purposes of this Section, "overdose" means a controlled substance-induced physiological event that results in a life-threatening emergency to the individual who ingested, inhaled, injected or otherwise bodily absorbed a controlled, counterfeit, or look-alike substance or a controlled substance analog.

(b) A person who, in good faith, seeks or obtains emergency medical assistance for someone experiencing an overdose shall not be arrested, charged, or prosecuted for a violation of Section 401 or 402 of the Illinois Controlled Substances Act, Section 3.5 of the Drug Paraphernalia Control Act, Section 55 or 60 of the Methamphetamine Control and Community Protection Act, Section 9-3.3 of the Criminal Code of 2012, or paragraph (1) of subsection (g) of Section 12-3.05 of the Criminal Code of 2012 ~~Class 4 felony possession of a controlled, counterfeit, or look-alike substance or a controlled substance analog~~ if evidence for the violation ~~Class 4 felony possession charge~~ was acquired as a result of the person seeking or obtaining emergency medical assistance and providing the amount of substance recovered is within the amount identified in subsection (d) of this Section. The violations listed in this

subsection (b) must not serve as the sole basis of a violation of parole, mandatory supervised release, probation, or conditional discharge, a Department of Children and Family Services investigation, or any seizure of property under any State law authorizing civil forfeiture so long as the evidence for the violation was acquired as a result of the person seeking or obtaining emergency medical assistance in the event of an overdose.

(c) A person who is experiencing an overdose shall not be arrested, charged, or prosecuted for a violation of Section 401 or 402 of the Illinois Controlled Substances Act, Section 3.5 of the Drug Paraphernalia Control Act, Section 9-3.3 of the Criminal Code of 2012, or paragraph (1) of subsection (g) of Section 12-3.05 of the Criminal Code of 2012 ~~Class 4 felony possession of a controlled, counterfeit, or look alike substance or a controlled substance analog~~ if evidence for the violation ~~Class 4 felony possession charge~~ was acquired as a result of the person seeking or obtaining emergency medical assistance and providing the amount of substance recovered is within the amount identified in subsection (d) of this Section. The violations listed in this subsection (c) must not serve as the sole basis of a violation of parole, mandatory supervised release, probation, or conditional discharge, a Department of Children and Family Services investigation, or any seizure of property under any State law authorizing civil forfeiture so long as the evidence for the violation was acquired as a result

of the person seeking or obtaining emergency medical assistance in the event of an overdose.

(d) For the purposes of subsections (b) and (c), the limited immunity shall only apply to a person possessing the following amount:

(1) less than 3 grams of a substance containing heroin;

(2) less than 3 grams of a substance containing cocaine;

(3) less than 3 grams of a substance containing morphine;

(4) less than 40 grams of a substance containing peyote;

(5) less than 40 grams of a substance containing a derivative of barbituric acid or any of the salts of a derivative of barbituric acid;

(6) less than 40 grams of a substance containing amphetamine or any salt of an optical isomer of amphetamine;

(7) less than 3 grams of a substance containing lysergic acid diethylamide (LSD), or an analog thereof;

(8) less than 6 grams of a substance containing pentazocine or any of the salts, isomers and salts of isomers of pentazocine, or an analog thereof;

(9) less than 6 grams of a substance containing methaqualone or any of the salts, isomers and salts of isomers of methaqualone;

(10) less than 6 grams of a substance containing phencyclidine or any of the salts, isomers and salts of isomers of phencyclidine (PCP);

(11) less than 6 grams of a substance containing ketamine or any of the salts, isomers and salts of isomers of ketamine;

(12) less than 40 grams of a substance containing a substance classified as a narcotic drug in Schedules I or II, or an analog thereof, which is not otherwise included in this subsection.

(e) The limited immunity described in subsections (b) and (c) of this Section shall not be extended if law enforcement has reasonable suspicion or probable cause to detain, arrest, or search the person described in subsection (b) or (c) of this Section for criminal activity and the reasonable suspicion or probable cause is based on information obtained prior to or independent of the individual described in subsection (b) or (c) taking action to seek or obtain emergency medical assistance and not obtained as a direct result of the action of seeking or obtaining emergency medical assistance. Nothing in this Section is intended to interfere with or prevent the investigation, arrest, or prosecution of any person for the delivery or distribution of cannabis, methamphetamine or other controlled substances, drug-induced homicide, or any other crime <u>if the evidence of the violation is not acquired as a result of the person seeking or obtaining emergency medical</u>

assistance in the event of an overdose.

(Source: P.A. 97-678, eff. 6-1-12.)

Section 50-10. The Methamphetamine Control and Community Protection Act is amended by changing Section 115 as follows:

(720 ILCS 646/115)

Sec. 115. Overdose; limited immunity ~~from prosecution~~.

(a) For the purposes of this Section, "overdose" means a methamphetamine-induced physiological event that results in a life-threatening emergency to the individual who ingested, inhaled, injected, or otherwise bodily absorbed methamphetamine.

(b) A person who, in good faith, seeks emergency medical assistance for someone experiencing an overdose shall not be arrested, charged or prosecuted for a violation of Section 55 or 60 of this Act or Section 3.5 of the Drug Paraphernalia Control Act, Section 9-3.3 of the Criminal Code of 2012, or paragraph (1) of subsection (g) of Section 12-3.05 of the Criminal Code of 2012 ~~Class 3 felony possession of methamphetamine~~ if evidence for the violation ~~Class 3 felony possession charge~~ was acquired as a result of the person seeking or obtaining emergency medical assistance and providing the amount of substance recovered is less than 3 grams ~~one gram~~ of methamphetamine or a substance containing methamphetamine. The violations listed in this subsection (b)

must not serve as the sole basis of a violation of parole, mandatory supervised release, probation, or conditional discharge, a Department of Children and Family Services investigation, or any seizure of property under any State law authorizing civil forfeiture so long as the evidence for the violation was acquired as a result of the person seeking or obtaining emergency medical assistance in the event of an overdose.

(c) A person who is experiencing an overdose shall not be arrested, charged, or prosecuted for a violation of Section 55 or 60 of this Act or Section 3.5 of the Drug Paraphernalia Control Act, Section 9-3.3 of the Criminal Code of 2012, or paragraph (1) of subsection (g) of Section 12-3.05 of the Criminal Code of 2012 ~~Class 3 felony possession of methamphetamine~~ if evidence for the Class 3 felony possession charge was acquired as a result of the person seeking or obtaining emergency medical assistance and providing the amount of substance recovered is less than one gram of methamphetamine or a substance containing methamphetamine. The violations listed in this subsection (c) must not serve as the sole basis of a violation of parole, mandatory supervised release, probation, or conditional discharge, a Department of Children and Family Services investigation, or any seizure of property under any State law authorizing civil forfeiture so long as the evidence for the violation was acquired as a result of the person seeking or obtaining emergency medical assistance

in the event of an overdose.

(d) The limited immunity described in subsections (b) and (c) of this Section shall not be extended if law enforcement has reasonable suspicion or probable cause to detain, arrest, or search the person described in subsection (b) or (c) of this Section for criminal activity and the reasonable suspicion or probable cause is based on information obtained prior to or independent of the individual described in subsection (b) or (c) taking action to seek or obtain emergency medical assistance and not obtained as a direct result of the action of seeking or obtaining emergency medical assistance. Nothing in this Section is intended to interfere with or prevent the investigation, arrest, or prosecution of any person for the delivery or distribution of cannabis, methamphetamine or other controlled substances, drug-induced homicide, or any other crime if the evidence of the violation is not acquired as a result of the person seeking or obtaining emergency medical assistance in the event of an overdose.

(Source: P.A. 97-678, eff. 6-1-12.)

Article 55.

Section 55-5. The Illinois Controlled Substances Act is amended by changing Section 316 as follows:

(720 ILCS 570/316)

Sec. 316. Prescription Monitoring Program.

(a) The Department must provide for a Prescription Monitoring Program for Schedule II, III, IV, and V controlled substances that includes the following components and requirements:

(1) The dispenser must transmit to the central repository, in a form and manner specified by the Department, the following information:

(A) The recipient's name and address.

(B) The recipient's date of birth and gender.

(C) The national drug code number of the controlled substance dispensed.

(D) The date the controlled substance is dispensed.

(E) The quantity of the controlled substance dispensed and days supply.

(F) The dispenser's United States Drug Enforcement Administration registration number.

(G) The prescriber's United States Drug Enforcement Administration registration number.

(H) The dates the controlled substance prescription is filled.

(I) The payment type used to purchase the controlled substance (i.e. Medicaid, cash, third party insurance).

(J) The patient location code (i.e. home, nursing

home, outpatient, etc.) for the controlled substances other than those filled at a retail pharmacy.

(K) Any additional information that may be required by the department by administrative rule, including but not limited to information required for compliance with the criteria for electronic reporting of the American Society for Automation and Pharmacy or its successor.

(2) The information required to be transmitted under this Section must be transmitted not later than the end of the next business day after the date on which a controlled substance is dispensed, or at such other time as may be required by the Department by administrative rule.

(3) A dispenser must transmit the information required under this Section by:

(A) an electronic device compatible with the receiving device of the central repository;

(B) a computer diskette;

(C) a magnetic tape; or

(D) a pharmacy universal claim form or Pharmacy Inventory Control form.

(3.5) The requirements of paragraphs (1), (2), and (3) of this subsection (a) also apply to opioid treatment programs that prescribe Schedule II, III, IV, or V controlled substances for the treatment of opioid use disorder.

(4) The Department may impose a civil fine of up to $100 per day for willful failure to report controlled substance dispensing to the Prescription Monitoring Program. The fine shall be calculated on no more than the number of days from the time the report was required to be made until the time the problem was resolved, and shall be payable to the Prescription Monitoring Program.

(a-5) Notwithstanding subsection (a), a licensed veterinarian is exempt from the reporting requirements of this Section. If a person who is presenting an animal for treatment is suspected of fraudulently obtaining any controlled substance or prescription for a controlled substance, the licensed veterinarian shall report that information to the local law enforcement agency.

(b) The Department, by rule, may include in the Prescription Monitoring Program certain other select drugs that are not included in Schedule II, III, IV, or V. The Prescription Monitoring Program does not apply to controlled substance prescriptions as exempted under Section 313.

(c) The collection of data on select drugs and scheduled substances by the Prescription Monitoring Program may be used as a tool for addressing oversight requirements of long-term care institutions as set forth by Public Act 96-1372. Long-term care pharmacies shall transmit patient medication profiles to the Prescription Monitoring Program monthly or more frequently as established by administrative rule.

(d) The Department of Human Services shall appoint a full-time Clinical Director of the Prescription Monitoring Program.

(e) (Blank).

(f) Within one year of January 1, 2018 (the effective date of Public Act 100-564), the Department shall adopt rules requiring all Electronic Health Records Systems to interface with the Prescription Monitoring Program application program on or before January 1, 2021 to ensure that all providers have access to specific patient records during the treatment of their patients. These rules shall also address the electronic integration of pharmacy records with the Prescription Monitoring Program to allow for faster transmission of the information required under this Section. The Department shall establish actions to be taken if a prescriber's Electronic Health Records System does not effectively interface with the Prescription Monitoring Program within the required timeline.

(g) The Department, in consultation with the Advisory Committee, shall adopt rules allowing licensed prescribers or pharmacists who have registered to access the Prescription Monitoring Program to authorize a licensed or non-licensed designee employed in that licensed prescriber's office or a licensed designee in a licensed pharmacist's pharmacy who has received training in the federal Health Insurance Portability and Accountability Act to consult the Prescription Monitoring Program on their behalf. The rules shall include reasonable

parameters concerning a practitioner's authority to authorize a designee, and the eligibility of a person to be selected as a designee. In this subsection (g), "pharmacist" shall include a clinical pharmacist employed by and designated by a Medicaid Managed Care Organization providing services under Article V of the Illinois Public Aid Code under a contract with the Department of Healthcare and Family Services for the sole purpose of clinical review of services provided to persons covered by the entity under the contract to determine compliance with subsections (a) and (b) of Section 314.5 of this Act. A managed care entity pharmacist shall notify prescribers of review activities.

(Source: P.A. 100-564, eff. 1-1-18; 100-861, eff. 8-14-18; 100-1005, eff. 8-21-18; 100-1093, eff. 8-26-18; 101-81, eff. 7-12-19; 101-414, eff. 8-16-19.)

Article 60.

Section 60-5. The Adult Protective Services Act is amended by adding Section 3.1 as follows:

(320 ILCS 20/3.1 new)

Sec. 3.1. Adult protective services dementia training.

(a) This Section shall apply to any person who is employed by the Department in the Adult Protective Services division who works on the development and implementation of social services

to respond to and prevent adult abuse, neglect, or exploitation.

(b) The Department shall develop and implement a dementia training program that must include instruction on the identification of people with dementia, risks such as wandering, communication impairments, elder abuse, and the best practices for interacting with people with dementia.

(c) Initial training of 4 hours shall be completed at the start of employment with the Adult Protective Services division and shall cover the following:

(1) Dementia, psychiatric, and behavioral symptoms.

(2) Communication issues, including how to communicate respectfully and effectively.

(3) Techniques for understanding and approaching behavioral symptoms.

(4) Information on how to address specific aspects of safety, for example tips to prevent wandering.

(5) When it is necessary to alert law enforcement agencies of potential criminal behavior involving a family member, caretaker, or institutional abuse; neglect or exploitation of a person with dementia; and what types of abuse that are most common to people with dementia.

(6) Identifying incidents of self-neglect for people with dementia who live alone as well as neglect by a caregiver.

(7) Protocols for connecting people living with

dementia to local care resources and professionals who are skilled in dementia care to encourage cross-referral and reporting regarding incidents of abuse.

(d) Annual continuing education shall include 2 hours of dementia training covering the subjects described in subsection (c).

(e) This Section is designed to address gaps in current dementia training requirements for Adult Protective Services officials and improve the quality of training. If currently existing law or rules contain more rigorous training requirements for Adult Protective Service officials, those laws or rules shall apply. Where there is overlap between this Section and other laws and rules, the Department shall interpret this Section to avoid duplication of requirements while ensuring that the minimum requirements set in this Section are met.

(f) The Department may adopt rules for the administration of this Section.

## Title VI. Access to Health Care

### Article 70.

Section 70-5. The Use Tax Act is amended by changing Section 3-10 as follows:

(35 ILCS 105/3-10)

Sec. 3-10. Rate of tax. Unless otherwise provided in this Section, the tax imposed by this Act is at the rate of 6.25% of either the selling price or the fair market value, if any, of the tangible personal property. In all cases where property functionally used or consumed is the same as the property that was purchased at retail, then the tax is imposed on the selling price of the property. In all cases where property functionally used or consumed is a by-product or waste product that has been refined, manufactured, or produced from property purchased at retail, then the tax is imposed on the lower of the fair market value, if any, of the specific property so used in this State or on the selling price of the property purchased at retail. For purposes of this Section "fair market value" means the price at which property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts. The fair market value shall be established by Illinois sales by the taxpayer of the same property as that functionally used or consumed, or if there are no such sales by the taxpayer, then comparable sales or purchases of property of like kind and character in Illinois.

Beginning on July 1, 2000 and through December 31, 2000, with respect to motor fuel, as defined in Section 1.1 of the Motor Fuel Tax Law, and gasohol, as defined in Section 3-40 of the Use Tax Act, the tax is imposed at the rate of 1.25%.

Beginning on August 6, 2010 through August 15, 2010, with respect to sales tax holiday items as defined in Section 3-6 of this Act, the tax is imposed at the rate of 1.25%.

With respect to gasohol, the tax imposed by this Act applies to (i) 70% of the proceeds of sales made on or after January 1, 1990, and before July 1, 2003, (ii) 80% of the proceeds of sales made on or after July 1, 2003 and on or before July 1, 2017, and (iii) 100% of the proceeds of sales made thereafter. If, at any time, however, the tax under this Act on sales of gasohol is imposed at the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of gasohol made during that time.

With respect to majority blended ethanol fuel, the tax imposed by this Act does not apply to the proceeds of sales made on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the proceeds of sales made thereafter.

With respect to biodiesel blends with no less than 1% and no more than 10% biodiesel, the tax imposed by this Act applies to (i) 80% of the proceeds of sales made on or after July 1, 2003 and on or before December 31, 2018 and (ii) 100% of the proceeds of sales made thereafter. If, at any time, however, the tax under this Act on sales of biodiesel blends with no less than 1% and no more than 10% biodiesel is imposed at the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of biodiesel blends with no less than

1% and no more than 10% biodiesel made during that time.

With respect to 100% biodiesel and biodiesel blends with more than 10% but no more than 99% biodiesel, the tax imposed by this Act does not apply to the proceeds of sales made on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the proceeds of sales made thereafter.

With respect to food for human consumption that is to be consumed off the premises where it is sold (other than alcoholic beverages, food consisting of or infused with adult use cannabis, soft drinks, and food that has been prepared for immediate consumption) and prescription and nonprescription medicines, drugs, medical appliances, products classified as Class III medical devices by the United States Food and Drug Administration that are used for cancer treatment pursuant to a prescription, as well as any accessories and components related to those devices, modifications to a motor vehicle for the purpose of rendering it usable by a person with a disability, and insulin, blood sugar ~~urine~~ testing materials, syringes, and needles used by human diabetics, ~~for human use,~~ the tax is imposed at the rate of 1%. For the purposes of this Section, until September 1, 2009: the term "soft drinks" means any complete, finished, ready-to-use, non-alcoholic drink, whether carbonated or not, including but not limited to soda water, cola, fruit juice, vegetable juice, carbonated water, and all other preparations commonly known as soft drinks of whatever kind or description that are contained in any closed or sealed

bottle, can, carton, or container, regardless of size; but "soft drinks" does not include coffee, tea, non-carbonated water, infant formula, milk or milk products as defined in the Grade A Pasteurized Milk and Milk Products Act, or drinks containing 50% or more natural fruit or vegetable juice.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "soft drinks" means non-alcoholic beverages that contain natural or artificial sweeteners. "Soft drinks" do not include beverages that contain milk or milk products, soy, rice or similar milk substitutes, or greater than 50% of vegetable or fruit juice by volume.

Until August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine. Beginning August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks, candy, and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "food for human consumption that is to be consumed off the premises where it is sold" does not

include candy. For purposes of this Section, "candy" means a preparation of sugar, honey, or other natural or artificial sweeteners in combination with chocolate, fruits, nuts or other ingredients or flavorings in the form of bars, drops, or pieces. "Candy" does not include any preparation that contains flour or requires refrigeration.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "nonprescription medicines and drugs" does not include grooming and hygiene products. For purposes of this Section, "grooming and hygiene products" includes, but is not limited to, soaps and cleaning solutions, shampoo, toothpaste, mouthwash, antiperspirants, and sun tan lotions and screens, unless those products are available by prescription only, regardless of whether the products meet the definition of "over-the-counter-drugs". For the purposes of this paragraph, "over-the-counter-drug" means a drug for human use that contains a label that identifies the product as a drug as required by 21 C.F.R. § 201.66. The "over-the-counter-drug" label includes:

(A) A "Drug Facts" panel; or

(B) A statement of the "active ingredient(s)" with a list of those ingredients contained in the compound, substance or preparation.

Beginning on the effective date of this amendatory Act of the 98th General Assembly, "prescription and nonprescription medicines and drugs" includes medical cannabis purchased from a

registered dispensing organization under the Compassionate Use of Medical Cannabis Program Act.

As used in this Section, "adult use cannabis" means cannabis subject to tax under the Cannabis Cultivation Privilege Tax Law and the Cannabis Purchaser Excise Tax Law and does not include cannabis subject to tax under the Compassionate Use of Medical Cannabis Program Act.

If the property that is purchased at retail from a retailer is acquired outside Illinois and used outside Illinois before being brought to Illinois for use here and is taxable under this Act, the "selling price" on which the tax is computed shall be reduced by an amount that represents a reasonable allowance for depreciation for the period of prior out-of-state use.

(Source: P.A. 100-22, eff. 7-6-17; 101-363, eff. 8-9-19; 101-593, eff. 12-4-19.)

Section 70-10. The Service Use Tax Act is amended by changing Section 3-10 as follows:

(35 ILCS 110/3-10) (from Ch. 120, par. 439.33-10)

Sec. 3-10. Rate of tax. Unless otherwise provided in this Section, the tax imposed by this Act is at the rate of 6.25% of the selling price of tangible personal property transferred as an incident to the sale of service, but, for the purpose of computing this tax, in no event shall the selling price be less

than the cost price of the property to the serviceman.

Beginning on July 1, 2000 and through December 31, 2000, with respect to motor fuel, as defined in Section 1.1 of the Motor Fuel Tax Law, and gasohol, as defined in Section 3-40 of the Use Tax Act, the tax is imposed at the rate of 1.25%.

With respect to gasohol, as defined in the Use Tax Act, the tax imposed by this Act applies to (i) 70% of the selling price of property transferred as an incident to the sale of service on or after January 1, 1990, and before July 1, 2003, (ii) 80% of the selling price of property transferred as an incident to the sale of service on or after July 1, 2003 and on or before July 1, 2017, and (iii) 100% of the selling price thereafter. If, at any time, however, the tax under this Act on sales of gasohol, as defined in the Use Tax Act, is imposed at the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of gasohol made during that time.

With respect to majority blended ethanol fuel, as defined in the Use Tax Act, the tax imposed by this Act does not apply to the selling price of property transferred as an incident to the sale of service on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the selling price thereafter.

With respect to biodiesel blends, as defined in the Use Tax Act, with no less than 1% and no more than 10% biodiesel, the tax imposed by this Act applies to (i) 80% of the selling price of property transferred as an incident to the sale of service

on or after July 1, 2003 and on or before December 31, 2018 and (ii) 100% of the proceeds of the selling price thereafter. If, at any time, however, the tax under this Act on sales of biodiesel blends, as defined in the Use Tax Act, with no less than 1% and no more than 10% biodiesel is imposed at the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of biodiesel blends with no less than 1% and no more than 10% biodiesel made during that time.

With respect to 100% biodiesel, as defined in the Use Tax Act, and biodiesel blends, as defined in the Use Tax Act, with more than 10% but no more than 99% biodiesel, the tax imposed by this Act does not apply to the proceeds of the selling price of property transferred as an incident to the sale of service on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the selling price thereafter.

At the election of any registered serviceman made for each fiscal year, sales of service in which the aggregate annual cost price of tangible personal property transferred as an incident to the sales of service is less than 35%, or 75% in the case of servicemen transferring prescription drugs or servicemen engaged in graphic arts production, of the aggregate annual total gross receipts from all sales of service, the tax imposed by this Act shall be based on the serviceman's cost price of the tangible personal property transferred as an incident to the sale of those services.

The tax shall be imposed at the rate of 1% on food prepared

for immediate consumption and transferred incident to a sale of service subject to this Act or the Service Occupation Tax Act by an entity licensed under the Hospital Licensing Act, the Nursing Home Care Act, the ID/DD Community Care Act, the MC/DD Act, the Specialized Mental Health Rehabilitation Act of 2013, or the Child Care Act of 1969. The tax shall also be imposed at the rate of 1% on food for human consumption that is to be consumed off the premises where it is sold (other than alcoholic beverages, food consisting of or infused with adult use cannabis, soft drinks, and food that has been prepared for immediate consumption and is not otherwise included in this paragraph) and prescription and nonprescription medicines, drugs, medical appliances, products classified as Class III medical devices by the United States Food and Drug Administration that are used for cancer treatment pursuant to a prescription, as well as any accessories and components related to those devices, modifications to a motor vehicle for the purpose of rendering it usable by a person with a disability, and insulin, blood sugar ~~urine~~ testing materials, syringes, and needles used by human diabetics~~, for human use~~. For the purposes of this Section, until September 1, 2009: the term "soft drinks" means any complete, finished, ready-to-use, non-alcoholic drink, whether carbonated or not, including but not limited to soda water, cola, fruit juice, vegetable juice, carbonated water, and all other preparations commonly known as soft drinks of whatever kind or description that are contained

in any closed or sealed bottle, can, carton, or container, regardless of size; but "soft drinks" does not include coffee, tea, non-carbonated water, infant formula, milk or milk products as defined in the Grade A Pasteurized Milk and Milk Products Act, or drinks containing 50% or more natural fruit or vegetable juice.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "soft drinks" means non-alcoholic beverages that contain natural or artificial sweeteners. "Soft drinks" do not include beverages that contain milk or milk products, soy, rice or similar milk substitutes, or greater than 50% of vegetable or fruit juice by volume.

Until August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine. Beginning August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks, candy, and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "food for human consumption that

is to be consumed off the premises where it is sold" does not include candy. For purposes of this Section, "candy" means a preparation of sugar, honey, or other natural or artificial sweeteners in combination with chocolate, fruits, nuts or other ingredients or flavorings in the form of bars, drops, or pieces. "Candy" does not include any preparation that contains flour or requires refrigeration.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "nonprescription medicines and drugs" does not include grooming and hygiene products. For purposes of this Section, "grooming and hygiene products" includes, but is not limited to, soaps and cleaning solutions, shampoo, toothpaste, mouthwash, antiperspirants, and sun tan lotions and screens, unless those products are available by prescription only, regardless of whether the products meet the definition of "over-the-counter-drugs". For the purposes of this paragraph, "over-the-counter-drug" means a drug for human use that contains a label that identifies the product as a drug as required by 21 C.F.R. § 201.66. The "over-the-counter-drug" label includes:

(A) A "Drug Facts" panel; or

(B) A statement of the "active ingredient(s)" with a list of those ingredients contained in the compound, substance or preparation.

Beginning on January 1, 2014 (the effective date of Public Act 98-122), "prescription and nonprescription medicines and

drugs" includes medical cannabis purchased from a registered dispensing organization under the Compassionate Use of Medical Cannabis Program Act.

As used in this Section, "adult use cannabis" means cannabis subject to tax under the Cannabis Cultivation Privilege Tax Law and the Cannabis Purchaser Excise Tax Law and does not include cannabis subject to tax under the Compassionate Use of Medical Cannabis Program Act.

If the property that is acquired from a serviceman is acquired outside Illinois and used outside Illinois before being brought to Illinois for use here and is taxable under this Act, the "selling price" on which the tax is computed shall be reduced by an amount that represents a reasonable allowance for depreciation for the period of prior out-of-state use.

(Source: P.A. 100-22, eff. 7-6-17; 101-363, eff. 8-9-19; 101-593, eff. 12-4-19.)

Section 70-15. The Service Occupation Tax Act is amended by changing Section 3-10 as follows:

(35 ILCS 115/3-10) (from Ch. 120, par. 439.103-10)

Sec. 3-10. Rate of tax. Unless otherwise provided in this Section, the tax imposed by this Act is at the rate of 6.25% of the "selling price", as defined in Section 2 of the Service Use Tax Act, of the tangible personal property. For the purpose of

computing this tax, in no event shall the "selling price" be less than the cost price to the serviceman of the tangible personal property transferred. The selling price of each item of tangible personal property transferred as an incident of a sale of service may be shown as a distinct and separate item on the serviceman's billing to the service customer. If the selling price is not so shown, the selling price of the tangible personal property is deemed to be 50% of the serviceman's entire billing to the service customer. When, however, a serviceman contracts to design, develop, and produce special order machinery or equipment, the tax imposed by this Act shall be based on the serviceman's cost price of the tangible personal property transferred incident to the completion of the contract.

Beginning on July 1, 2000 and through December 31, 2000, with respect to motor fuel, as defined in Section 1.1 of the Motor Fuel Tax Law, and gasohol, as defined in Section 3-40 of the Use Tax Act, the tax is imposed at the rate of 1.25%.

With respect to gasohol, as defined in the Use Tax Act, the tax imposed by this Act shall apply to (i) 70% of the cost price of property transferred as an incident to the sale of service on or after January 1, 1990, and before July 1, 2003, (ii) 80% of the selling price of property transferred as an incident to the sale of service on or after July 1, 2003 and on or before July 1, 2017, and (iii) 100% of the cost price thereafter. If, at any time, however, the tax under this Act on

sales of gasohol, as defined in the Use Tax Act, is imposed at the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of gasohol made during that time.

With respect to majority blended ethanol fuel, as defined in the Use Tax Act, the tax imposed by this Act does not apply to the selling price of property transferred as an incident to the sale of service on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the selling price thereafter.

With respect to biodiesel blends, as defined in the Use Tax Act, with no less than 1% and no more than 10% biodiesel, the tax imposed by this Act applies to (i) 80% of the selling price of property transferred as an incident to the sale of service on or after July 1, 2003 and on or before December 31, 2018 and (ii) 100% of the proceeds of the selling price thereafter. If, at any time, however, the tax under this Act on sales of biodiesel blends, as defined in the Use Tax Act, with no less than 1% and no more than 10% biodiesel is imposed at the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of biodiesel blends with no less than 1% and no more than 10% biodiesel made during that time.

With respect to 100% biodiesel, as defined in the Use Tax Act, and biodiesel blends, as defined in the Use Tax Act, with more than 10% but no more than 99% biodiesel material, the tax imposed by this Act does not apply to the proceeds of the selling price of property transferred as an incident to the

sale of service on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the selling price thereafter.

At the election of any registered serviceman made for each fiscal year, sales of service in which the aggregate annual cost price of tangible personal property transferred as an incident to the sales of service is less than 35%, or 75% in the case of servicemen transferring prescription drugs or servicemen engaged in graphic arts production, of the aggregate annual total gross receipts from all sales of service, the tax imposed by this Act shall be based on the serviceman's cost price of the tangible personal property transferred incident to the sale of those services.

The tax shall be imposed at the rate of 1% on food prepared for immediate consumption and transferred incident to a sale of service subject to this Act or the Service Occupation Tax Act by an entity licensed under the Hospital Licensing Act, the Nursing Home Care Act, the ID/DD Community Care Act, the MC/DD Act, the Specialized Mental Health Rehabilitation Act of 2013, or the Child Care Act of 1969. The tax shall also be imposed at the rate of 1% on food for human consumption that is to be consumed off the premises where it is sold (other than alcoholic beverages, food consisting of or infused with adult use cannabis, soft drinks, and food that has been prepared for immediate consumption and is not otherwise included in this paragraph) and prescription and nonprescription medicines,

drugs, medical appliances, products classified as Class III medical devices by the United States Food and Drug Administration that are used for cancer treatment pursuant to a prescription, as well as any accessories and components related to those devices, modifications to a motor vehicle for the purpose of rendering it usable by a person with a disability, and insulin, blood sugar ~~urine~~ testing materials, syringes, and needles used by human diabetics~~, for human use~~. For the purposes of this Section, until September 1, 2009: the term "soft drinks" means any complete, finished, ready-to-use, non-alcoholic drink, whether carbonated or not, including but not limited to soda water, cola, fruit juice, vegetable juice, carbonated water, and all other preparations commonly known as soft drinks of whatever kind or description that are contained in any closed or sealed can, carton, or container, regardless of size; but "soft drinks" does not include coffee, tea, non-carbonated water, infant formula, milk or milk products as defined in the Grade A Pasteurized Milk and Milk Products Act, or drinks containing 50% or more natural fruit or vegetable juice.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "soft drinks" means non-alcoholic beverages that contain natural or artificial sweeteners. "Soft drinks" do not include beverages that contain milk or milk products, soy, rice or similar milk substitutes, or greater than 50% of vegetable or fruit juice by volume.

Until August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine. Beginning August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks, candy, and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "food for human consumption that is to be consumed off the premises where it is sold" does not include candy. For purposes of this Section, "candy" means a preparation of sugar, honey, or other natural or artificial sweeteners in combination with chocolate, fruits, nuts or other ingredients or flavorings in the form of bars, drops, or pieces. "Candy" does not include any preparation that contains flour or requires refrigeration.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "nonprescription medicines and drugs" does not include grooming and hygiene products. For purposes of this Section, "grooming and hygiene products" includes, but is not limited to, soaps and cleaning solutions,

shampoo, toothpaste, mouthwash, antiperspirants, and sun tan lotions and screens, unless those products are available by prescription only, regardless of whether the products meet the definition of "over-the-counter-drugs". For the purposes of this paragraph, "over-the-counter-drug" means a drug for human use that contains a label that identifies the product as a drug as required by 21 C.F.R. § 201.66. The "over-the-counter-drug" label includes:

(A) A "Drug Facts" panel; or

(B) A statement of the "active ingredient(s)" with a list of those ingredients contained in the compound, substance or preparation.

Beginning on January 1, 2014 (the effective date of Public Act 98-122), "prescription and nonprescription medicines and drugs" includes medical cannabis purchased from a registered dispensing organization under the Compassionate Use of Medical Cannabis Program Act.

As used in this Section, "adult use cannabis" means cannabis subject to tax under the Cannabis Cultivation Privilege Tax Law and the Cannabis Purchaser Excise Tax Law and does not include cannabis subject to tax under the Compassionate Use of Medical Cannabis Program Act.

(Source: P.A. 100-22, eff. 7-6-17; 101-363, eff. 8-9-19; 101-593, eff. 12-4-19.)

Section 70-20. The Retailers' Occupation Tax Act is amended

by changing Section 2-10 as follows:

(35 ILCS 120/2-10)

Sec. 2-10. Rate of tax. Unless otherwise provided in this Section, the tax imposed by this Act is at the rate of 6.25% of gross receipts from sales of tangible personal property made in the course of business.

Beginning on July 1, 2000 and through December 31, 2000, with respect to motor fuel, as defined in Section 1.1 of the Motor Fuel Tax Law, and gasohol, as defined in Section 3-40 of the Use Tax Act, the tax is imposed at the rate of 1.25%.

Beginning on August 6, 2010 through August 15, 2010, with respect to sales tax holiday items as defined in Section 2-8 of this Act, the tax is imposed at the rate of 1.25%.

Within 14 days after the effective date of this amendatory Act of the 91st General Assembly, each retailer of motor fuel and gasohol shall cause the following notice to be posted in a prominently visible place on each retail dispensing device that is used to dispense motor fuel or gasohol in the State of Illinois: "As of July 1, 2000, the State of Illinois has eliminated the State's share of sales tax on motor fuel and gasohol through December 31, 2000. The price on this pump should reflect the elimination of the tax." The notice shall be printed in bold print on a sign that is no smaller than 4 inches by 8 inches. The sign shall be clearly visible to customers. Any retailer who fails to post or maintain a

required sign through December 31, 2000 is guilty of a petty offense for which the fine shall be $500 per day per each retail premises where a violation occurs.

With respect to gasohol, as defined in the Use Tax Act, the tax imposed by this Act applies to (i) 70% of the proceeds of sales made on or after January 1, 1990, and before July 1, 2003, (ii) 80% of the proceeds of sales made on or after July 1, 2003 and on or before July 1, 2017, and (iii) 100% of the proceeds of sales made thereafter. If, at any time, however, the tax under this Act on sales of gasohol, as defined in the Use Tax Act, is imposed at the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of gasohol made during that time.

With respect to majority blended ethanol fuel, as defined in the Use Tax Act, the tax imposed by this Act does not apply to the proceeds of sales made on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the proceeds of sales made thereafter.

With respect to biodiesel blends, as defined in the Use Tax Act, with no less than 1% and no more than 10% biodiesel, the tax imposed by this Act applies to (i) 80% of the proceeds of sales made on or after July 1, 2003 and on or before December 31, 2018 and (ii) 100% of the proceeds of sales made thereafter. If, at any time, however, the tax under this Act on sales of biodiesel blends, as defined in the Use Tax Act, with no less than 1% and no more than 10% biodiesel is imposed at

the rate of 1.25%, then the tax imposed by this Act applies to 100% of the proceeds of sales of biodiesel blends with no less than 1% and no more than 10% biodiesel made during that time.

With respect to 100% biodiesel, as defined in the Use Tax Act, and biodiesel blends, as defined in the Use Tax Act, with more than 10% but no more than 99% biodiesel, the tax imposed by this Act does not apply to the proceeds of sales made on or after July 1, 2003 and on or before December 31, 2023 but applies to 100% of the proceeds of sales made thereafter.

With respect to food for human consumption that is to be consumed off the premises where it is sold (other than alcoholic beverages, food consisting of or infused with adult use cannabis, soft drinks, and food that has been prepared for immediate consumption) and prescription and nonprescription medicines, drugs, medical appliances, products classified as Class III medical devices by the United States Food and Drug Administration that are used for cancer treatment pursuant to a prescription, as well as any accessories and components related to those devices, modifications to a motor vehicle for the purpose of rendering it usable by a person with a disability, and insulin, blood sugar ~~urine~~ testing materials, syringes, and needles used by human diabetics, ~~for human use,~~ the tax is imposed at the rate of 1%. For the purposes of this Section, until September 1, 2009: the term "soft drinks" means any complete, finished, ready-to-use, non-alcoholic drink, whether carbonated or not, including but not limited to soda water,

cola, fruit juice, vegetable juice, carbonated water, and all other preparations commonly known as soft drinks of whatever kind or description that are contained in any closed or sealed bottle, can, carton, or container, regardless of size; but "soft drinks" does not include coffee, tea, non-carbonated water, infant formula, milk or milk products as defined in the Grade A Pasteurized Milk and Milk Products Act, or drinks containing 50% or more natural fruit or vegetable juice.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "soft drinks" means non-alcoholic beverages that contain natural or artificial sweeteners. "Soft drinks" do not include beverages that contain milk or milk products, soy, rice or similar milk substitutes, or greater than 50% of vegetable or fruit juice by volume.

Until August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine. Beginning August 1, 2009, and notwithstanding any other provisions of this Act, "food for human consumption that is to be consumed off the premises where it is sold" includes all food sold through a vending machine, except soft drinks, candy, and food products that are dispensed hot from a vending machine, regardless of the location of the vending machine.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "food for human consumption that is to be consumed off the premises where it is sold" does not include candy. For purposes of this Section, "candy" means a preparation of sugar, honey, or other natural or artificial sweeteners in combination with chocolate, fruits, nuts or other ingredients or flavorings in the form of bars, drops, or pieces. "Candy" does not include any preparation that contains flour or requires refrigeration.

Notwithstanding any other provisions of this Act, beginning September 1, 2009, "nonprescription medicines and drugs" does not include grooming and hygiene products. For purposes of this Section, "grooming and hygiene products" includes, but is not limited to, soaps and cleaning solutions, shampoo, toothpaste, mouthwash, antiperspirants, and sun tan lotions and screens, unless those products are available by prescription only, regardless of whether the products meet the definition of "over-the-counter-drugs". For the purposes of this paragraph, "over-the-counter-drug" means a drug for human use that contains a label that identifies the product as a drug as required by 21 C.F.R. § 201.66. The "over-the-counter-drug" label includes:

(A) A "Drug Facts" panel; or

(B) A statement of the "active ingredient(s)" with a list of those ingredients contained in the compound, substance or preparation.

Beginning on the effective date of this amendatory Act of the 98th General Assembly, "prescription and nonprescription medicines and drugs" includes medical cannabis purchased from a registered dispensing organization under the Compassionate Use of Medical Cannabis Program Act.

As used in this Section, "adult use cannabis" means cannabis subject to tax under the Cannabis Cultivation Privilege Tax Law and the Cannabis Purchaser Excise Tax Law and does not include cannabis subject to tax under the Compassionate Use of Medical Cannabis Program Act.

(Source: P.A. 100-22, eff. 7-6-17; 101-363, eff. 8-9-19; 101-593, eff. 12-4-19.)

Article 75.

Section 75-5. The Illinois Public Aid Code is amended by changing Section 9A-11 as follows:

(305 ILCS 5/9A-11) (from Ch. 23, par. 9A-11)

Sec. 9A-11. Child care.

(a) The General Assembly recognizes that families with children need child care in order to work. Child care is expensive and families with low incomes, including those who are transitioning from welfare to work, often struggle to pay the costs of day care. The General Assembly understands the importance of helping low-income working families become and

remain self-sufficient. The General Assembly also believes that it is the responsibility of families to share in the costs of child care. It is also the preference of the General Assembly that all working poor families should be treated equally, regardless of their welfare status.

(b) To the extent resources permit, the Illinois Department shall provide child care services to parents or other relatives as defined by rule who are working or participating in employment or Department approved education or training programs. At a minimum, the Illinois Department shall cover the following categories of families:

(1) recipients of TANF under Article IV participating in work and training activities as specified in the personal plan for employment and self-sufficiency;

(2) families transitioning from TANF to work;

(3) families at risk of becoming recipients of TANF;

(4) families with special needs as defined by rule;

(5) working families with very low incomes as defined by rule;

(6) families that are not recipients of TANF and that need child care assistance to participate in education and training activities; and

(7) families with children under the age of 5 who have an open intact family services case with the Department of Children and Family Services. Any family that receives child care assistance in accordance with this paragraph

shall remain eligible for child care assistance 6 months after the child's intact family services case is closed, regardless of whether the child's parents or other relatives as defined by rule are working or participating in Department approved employment or education or training programs. The Department of Human Services, in consultation with the Department of Children and Family Services, shall adopt rules to protect the privacy of families who are the subject of an open intact family services case when such families enroll in child care services. Additional rules shall be adopted to offer children who have an open intact family services case the opportunity to receive an Early Intervention screening and other services that their families may be eligible for as provided by the Department of Human Services.

The Department shall specify by rule the conditions of eligibility, the application process, and the types, amounts, and duration of services. Eligibility for child care benefits and the amount of child care provided may vary based on family size, income, and other factors as specified by rule.

The Department shall update the Child Care Assistance Program Eligibility Calculator posted on its website to include a question on whether a family is applying for child care assistance for the first time or is applying for a redetermination of eligibility.

A family's eligibility for child care services shall be

redetermined no sooner than 12 months following the initial determination or most recent redetermination. During the 12-month periods, the family shall remain eligible for child care services regardless of (i) a change in family income, unless family income exceeds 85% of State median income, or (ii) a temporary change in the ongoing status of the parents or other relatives, as defined by rule, as working or attending a job training or educational program.

In determining income eligibility for child care benefits, the Department annually, at the beginning of each fiscal year, shall establish, by rule, one income threshold for each family size, in relation to percentage of State median income for a family of that size, that makes families with incomes below the specified threshold eligible for assistance and families with incomes above the specified threshold ineligible for assistance. Through and including fiscal year 2007, the specified threshold must be no less than 50% of the then-current State median income for each family size. Beginning in fiscal year 2008, the specified threshold must be no less than 185% of the then-current federal poverty level for each family size. Notwithstanding any other provision of law or administrative rule to the contrary, beginning in fiscal year 2019, the specified threshold for working families with very low incomes as defined by rule must be no less than 185% of the then-current federal poverty level for each family size.

In determining eligibility for assistance, the Department

shall not give preference to any category of recipients or give preference to individuals based on their receipt of benefits under this Code.

Nothing in this Section shall be construed as conferring entitlement status to eligible families.

The Illinois Department is authorized to lower income eligibility ceilings, raise parent co-payments, create waiting lists, or take such other actions during a fiscal year as are necessary to ensure that child care benefits paid under this Article do not exceed the amounts appropriated for those child care benefits. These changes may be accomplished by emergency rule under Section 5-45 of the Illinois Administrative Procedure Act, except that the limitation on the number of emergency rules that may be adopted in a 24-month period shall not apply.

The Illinois Department may contract with other State agencies or child care organizations for the administration of child care services.

(c) Payment shall be made for child care that otherwise meets the requirements of this Section and applicable standards of State and local law and regulation, including any requirements the Illinois Department promulgates by rule in addition to the licensure requirements promulgated by the Department of Children and Family Services and Fire Prevention and Safety requirements promulgated by the Office of the State Fire Marshal, and is provided in any of the following:

(1) a child care center which is licensed or exempt from licensure pursuant to Section 2.09 of the Child Care Act of 1969;

(2) a licensed child care home or home exempt from licensing;

(3) a licensed group child care home;

(4) other types of child care, including child care provided by relatives or persons living in the same home as the child, as determined by the Illinois Department by rule.

(c-5) Solely for the purposes of coverage under the Illinois Public Labor Relations Act, child and day care home providers, including licensed and license exempt, participating in the Department's child care assistance program shall be considered to be public employees and the State of Illinois shall be considered to be their employer as of January 1, 2006 (the effective date of Public Act 94-320), but not before. The State shall engage in collective bargaining with an exclusive representative of child and day care home providers participating in the child care assistance program concerning their terms and conditions of employment that are within the State's control. Nothing in this subsection shall be understood to limit the right of families receiving services defined in this Section to select child and day care home providers or supervise them within the limits of this Section. The State shall not be considered to be the employer of child

and day care home providers for any purposes not specifically provided in Public Act 94-320, including, but not limited to, purposes of vicarious liability in tort and purposes of statutory retirement or health insurance benefits. Child and day care home providers shall not be covered by the State Employees Group Insurance Act of 1971.

In according child and day care home providers and their selected representative rights under the Illinois Public Labor Relations Act, the State intends that the State action exemption to application of federal and State antitrust laws be fully available to the extent that their activities are authorized by Public Act 94-320.

(d) The Illinois Department shall establish, by rule, a co-payment scale that provides for cost sharing by families that receive child care services, including parents whose only income is from assistance under this Code. The co-payment shall be based on family income and family size and may be based on other factors as appropriate. Co-payments may be waived for families whose incomes are at or below the federal poverty level.

(d-5) The Illinois Department, in consultation with its Child Care and Development Advisory Council, shall develop a plan to revise the child care assistance program's co-payment scale. The plan shall be completed no later than February 1, 2008, and shall include:

(1) findings as to the percentage of income that the

average American family spends on child care and the relative amounts that low-income families and the average American family spend on other necessities of life;

(2) recommendations for revising the child care co-payment scale to assure that families receiving child care services from the Department are paying no more than they can reasonably afford;

(3) recommendations for revising the child care co-payment scale to provide at-risk children with complete access to Preschool for All and Head Start; and

(4) recommendations for changes in child care program policies that affect the affordability of child care.

(e) (Blank).

(f) The Illinois Department shall, by rule, set rates to be paid for the various types of child care. Child care may be provided through one of the following methods:

(1) arranging the child care through eligible providers by use of purchase of service contracts or vouchers;

(2) arranging with other agencies and community volunteer groups for non-reimbursed child care;

(3) (blank); or

(4) adopting such other arrangements as the Department determines appropriate.

(f-1) Within 30 days after June 4, 2018 (the effective date of Public Act 100-587), the Department of Human Services shall

establish rates for child care providers that are no less than the rates in effect on January 1, 2018 increased by 4.26%.

(f-5) (Blank).

(g) Families eligible for assistance under this Section shall be given the following options:

(1) receiving a child care certificate issued by the Department or a subcontractor of the Department that may be used by the parents as payment for child care and development services only; or

(2) if space is available, enrolling the child with a child care provider that has a purchase of service contract with the Department or a subcontractor of the Department for the provision of child care and development services. The Department may identify particular priority populations for whom they may request special consideration by a provider with purchase of service contracts, provided that the providers shall be permitted to maintain a balance of clients in terms of household incomes and families and children with special needs, as defined by rule.

(Source: P.A. 100-387, eff. 8-25-17; 100-587, eff. 6-4-18; 100-860, eff. 2-14-19; 100-909, eff. 10-1-18; 100-916, eff. 8-17-18; 101-81, eff. 7-12-19.)

Article 80.

Section 80-5. The Employee Sick Leave Act is amended by changing Sections 5 and 10 as follows:

(820 ILCS 191/5)

Sec. 5. Definitions. In this Act:

"Department" means the Department of Labor.

"Personal sick leave benefits" means any paid or unpaid time available to an employee as provided through an employment benefit plan or paid time off policy to be used as a result of absence from work due to personal illness, injury, or medical appointment or for the personal care of a parent, mother-in-law, father-in-law, grandparent, or stepparent. An employment benefit plan or paid time off policy does not include long term disability, short term disability, an insurance policy, or other comparable benefit plan or policy.

(Source: P.A. 99-841, eff. 1-1-17; 99-921, eff. 1-13-17.)

(820 ILCS 191/10)

Sec. 10. Use of leave; limitations.

(a) An employee may use personal sick leave benefits provided by the employer for absences due to an illness, injury, or medical appointment of the employee's child, stepchild, spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent, or for the personal care of a parent, mother-in-law, father-in-law, grandparent, or stepparent on

the same terms upon which the employee is able to use personal sick leave benefits for the employee's own illness or injury. An employer may request written verification of the employee's absence from a health care professional if such verification is required under the employer's employment benefit plan or paid time off policy.

(b) An employer may limit the use of personal sick leave benefits provided by the employer for absences due to an illness, injury, or medical appointment of the employee's child, stepchild, spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent to an amount not less than the personal sick leave that would be earned or accrued during 6 months at the employee's then current rate of entitlement. For employers who base personal sick leave benefits on an employee's years of service instead of annual or monthly accrual, such employer may limit the amount of sick leave to be used under this Act to half of the employee's maximum annual grant.

(c) An employer who provides personal sick leave benefits or a paid time off policy that would otherwise provide benefits as required under subsections (a) and (b) shall not be required to modify such benefits.

(Source: P.A. 99-841, eff. 1-1-17; 99-921, eff. 1-13-17.)

Article 90.

Section 90-5. The Nursing Home Care Act is amended by adding Section 3-206.06 as follows:

(210 ILCS 45/3-206.06 new)

Sec. 3-206.06. Testing for Legionnaires' disease. A facility licensed under this Act must prove upon inspection by the Department that it has provided testing for Legionnaires' disease. The facility must also provide the results of that testing to the Department.

Section 90-10. The Hospital Licensing Act is amended by adding Section 6.29 as follows:

(210 ILCS 85/6.29 new)

Sec. 6.29. Testing for Legionnaires' disease. A hospital licensed under this Act must prove upon inspection by the Department that it has provided testing for Legionnaires' disease. The hospital must also provide the results of that testing to the Department.

## Article 95.

Section 95-1. Short title. This Article may be cited as the Child Trauma Counseling Act. References in this Article to "this Act" mean this Article.

Section 95-5. Definitions. As used in this Act:

"Day care center" has the meaning given to that term in Section 2.09 of the Child Care Act of 1969.

"School" means a public or nonpublic elementary school.

"Trauma counselor" means a licensed professional counselor, as that term is defined in Section 10 of the Professional Counselor and Clinical Professional Counselor Licensing and Practice Act, who has experience in treating childhood trauma or who has a certification relating to treating childhood trauma.

Section 95-10. Trauma counseling through fifth grade.

(a) Notwithstanding any other provision of law:

(1) a day care center shall provide the services of a trauma counselor to a child, from birth through the fifth grade, enrolled and attending the day care center who has been identified as needing trauma counseling; and

(2) a school shall provide the services of a trauma counselor to a child who is enrolled and attending kindergarten through the fifth grade at that school and has been identified as needing trauma counseling.

There shall be no cost for such trauma counseling to the parents or guardians of the child.

(b) A child is identified as needing trauma counseling under subsection (a) if the child reports trauma to a day care center or a school or a parent or guardian of the child or

employee of a day care center or a school reports that the child has experienced trauma.

Section 95-15. Rules.

(a) The Department of Children and Family Services shall adopt rules to implement this Act. The Department shall seek recommendations and advice from the State Board of Education as to adoption of the Department's rules as they relate to schools.

(b) The Department of Financial and Professional Regulation may adopt rules regarding the qualifications of trauma counselors working with children under this Act.

Section 95-90. The State Mandates Act is amended by adding Section 8.45 as follows:

(30 ILCS 805/8.45 new)

Sec. 8.45. Exempt mandate. Notwithstanding Sections 6 and 8 of this Act, no reimbursement by the State is required for the implementation of any mandate created by the Child Trauma Counseling Act.

Article 100.

Section 100-1. Short title. This Article may be cited as the Special Commission on Gynecologic Cancers Act.

Section 100-5. Creation; members; duties; report.

(a) The Special Commission on Gynecologic Cancers is created. Membership of the Commission shall be as follows:

(1) A representative of the Illinois Comprehensive Cancer Control Program, appointed by the Director of Public Health;

(2) The Director of Insurance, or his or her designee; and

(3) 20 members who shall be appointed as follows:

(A) three members appointed by the Speaker of the House of Representatives, one of whom shall be a survivor of ovarian cancer, one of whom shall be a survivor of cervical, vaginal, vulvar, or uterine cancer, and one of whom shall be a medical specialist in gynecologic cancers;

(B) three members appointed by the Senate President, one of whom shall be a survivor of ovarian cancer, one of whom shall be a survivor of cervical, vaginal, vulvar, or uterine cancer, and one of whom shall be a medical specialist in gynecologic cancers;

(C) three members appointed by the House Minority Leader, one of whom shall be a survivor of ovarian cancer, one of whom shall be a survivor of cervical, vaginal, vulvar, or uterine cancer, and one of whom shall be a medical specialist in gynecologic

cancers;

(D) three members appointed by the Senate Minority Leader, one of whom shall be a survivor of ovarian cancer, one of whom shall be a survivor of cervical, vaginal, vulvar, or uterine cancer, and one of whom shall be a medical specialist in gynecologic cancers; and

(E) eight members appointed by the Governor, one of whom shall be a caregiver of a woman diagnosed with a gynecologic cancer, one of whom shall be a medical specialist in gynecologic cancers, one of whom shall be an individual with expertise in community based health care and issues affecting underserved and vulnerable populations, 2 of whom shall be individuals representing gynecologic cancer awareness and support groups in the State, one of whom shall be a researcher specializing in gynecologic cancers, and 2 of whom shall be members of the public with demonstrated expertise in issues relating to the work of the Commission.

(b) Members of the Commission shall serve without compensation or reimbursement from the Commission. Members shall select a Chair from among themselves and the Chair shall set the meeting schedule.

(c) The Illinois Department of Public Health shall provide administrative support to the Commission.

(d) The Commission is charged with the study of the following:

(1) establishing a mechanism to ascertain the prevalence of gynecologic cancers in the State and, to the extent possible, to collect statistics relative to the timing of diagnosis and risk factors associated with gynecologic cancers;

(2) determining how to best effectuate early diagnosis and treatment for gynecologic cancer patients;

(3) determining best practices for closing disparities in outcomes for gynecologic cancer patients and innovative approaches to reaching underserved and vulnerable populations;

(4) determining any unmet needs of persons with gynecologic cancers and those of their families; and

(5) providing recommendations for additional legislation, support programs, and resources to meet the unmet needs of persons with gynecologic cancers and their families.

(e) The Commission shall file its final report with the General Assembly no later than December 31, 2021 and, upon the filing of its report, is dissolved.

Section 100-90. Repeal. This Article is repealed on January 1, 2023.

Article 105.

Section 5. The Illinois Public Aid Code is amended by changing Section 5A-12.7 as follows:

(305 ILCS 5/5A-12.7)

(Section scheduled to be repealed on December 31, 2022)

Sec. 5A-12.7. Continuation of hospital access payments on and after July 1, 2020.

(a) To preserve and improve access to hospital services, for hospital services rendered on and after July 1, 2020, the Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals or require capitated managed care organizations to make payments as set forth in this Section. Payments under this Section are not due and payable, however, until: (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment or directed payment preprint; and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act. In determining the hospital access payments authorized under subsection (g) of this Section, if a hospital ceases to qualify for payments from the pool, the payments for all hospitals continuing to qualify for payments from such pool shall be uniformly adjusted to fully expend the aggregate net amount of the pool, with such adjustment being

effective on the first day of the second month following the date the hospital ceases to receive payments from such pool.

(b) Amounts moved into claims-based rates and distributed in accordance with Section 14-12 shall remain in those claims-based rates.

(c) Graduate medical education.

(1) The calculation of graduate medical education payments shall be based on the hospital's Medicare cost report ending in Calendar Year 2018, as reported in the Healthcare Cost Report Information System file, release date September 30, 2019. An Illinois hospital reporting intern and resident cost on its Medicare cost report shall be eligible for graduate medical education payments.

(2) Each hospital's annualized Medicaid Intern Resident Cost is calculated using annualized intern and resident total costs obtained from Worksheet B Part I, Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93, 96-98, and 105-112 multiplied by the percentage that the hospital's Medicaid days (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of the hospital's total days (Worksheet S3 Part I, Column 8, Lines 14, 16-18, and 32).

(3) An annualized Medicaid indirect medical education (IME) payment is calculated for each hospital using its IME payments (Worksheet E Part A, Line 29, Column 1) multiplied by the percentage that its Medicaid days (Worksheet S3 Part

I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of its Medicare days (Worksheet S3 Part I, Column 6, Lines 2, 3, 4, 14, and 16-18).

(4) For each hospital, its annualized Medicaid Intern Resident Cost and its annualized Medicaid IME payment are summed, and, except as capped at 120% of the average cost per intern and resident for all qualifying hospitals as calculated under this paragraph, is multiplied by 22.6% to determine the hospital's final graduate medical education payment. Each hospital's average cost per intern and resident shall be calculated by summing its total annualized Medicaid Intern Resident Cost plus its annualized Medicaid IME payment and dividing that amount by the hospital's total Full Time Equivalent Residents and Interns. If the hospital's average per intern and resident cost is greater than 120% of the same calculation for all qualifying hospitals, the hospital's per intern and resident cost shall be capped at 120% of the average cost for all qualifying hospitals.

(d) Fee-for-service supplemental payments. Each Illinois hospital shall receive an annual payment equal to the amounts below, to be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 30 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver

required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable.

(1) For critical access hospitals, $385 per covered inpatient day contained in paid fee-for-service claims and $530 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(2) For safety-net hospitals, $960 per covered inpatient day contained in paid fee-for-service claims and $625 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(3) For long term acute care hospitals, $295 per covered inpatient day contained in paid fee-for-service claims for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(4) For freestanding psychiatric hospitals, $125 per covered inpatient day contained in paid fee-for-service claims and $130 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(5) For freestanding rehabilitation hospitals, $355 per covered inpatient day contained in paid fee-for-service claims for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as

of May 11, 2020.

(6) For all general acute care hospitals and high Medicaid hospitals as defined in subsection (f), $350 per covered inpatient day for dates of service in Calendar Year 2019 contained in paid fee-for-service claims and $620 per paid fee-for-service outpatient claim in the Department's Enterprise Data Warehouse as of May 11, 2020.

(7) Alzheimer's treatment access payment. Each Illinois academic medical center or teaching hospital, as defined in Section 5-5e.2 of this Code, that is identified as the primary hospital affiliate of one of the Regional Alzheimer's Disease Assistance Centers, as designated by the Alzheimer's Disease Assistance Act and identified in the Department of Public Health's Alzheimer's Disease State Plan dated December 2016, shall be paid an Alzheimer's treatment access payment equal to the product of the qualifying hospital's State Fiscal Year 2018 total inpatient fee-for-service days multiplied by the applicable Alzheimer's treatment rate of $226.30 for hospitals located in Cook County and $116.21 for hospitals located outside Cook County.

(e) The Department shall require managed care organizations (MCOs) to make directed payments and pass-through payments according to this Section. Each calendar year, the Department shall require MCOs to pay the maximum amount out of these funds as allowed as pass-through payments

under federal regulations. The Department shall require MCOs to make such pass-through payments as specified in this Section. The Department shall require the MCOs to pay the remaining amounts as directed Payments as specified in this Section. The Department shall issue payments to the Comptroller by the seventh business day of each month for all MCOs that are sufficient for MCOs to make the directed payments and pass-through payments according to this Section. The Department shall require the MCOs to make pass-through payments and directed payments using electronic funds transfers (EFT), if the hospital provides the information necessary to process such EFTs, in accordance with directions provided monthly by the Department, within 7 business days of the date the funds are paid to the MCOs, as indicated by the "Paid Date" on the website of the Office of the Comptroller if the funds are paid by EFT and the MCOs have received directed payment instructions. If funds are not paid through the Comptroller by EFT, payment must be made within 7 business days of the date actually received by the MCO. The MCO will be considered to have paid the pass-through payments when the payment remittance number is generated or the date the MCO sends the check to the hospital, if EFT information is not supplied. If an MCO is late in paying a pass-through payment or directed payment as required under this Section (including any extensions granted by the Department), it shall pay a penalty, unless waived by the Department for reasonable cause, to the Department equal to

5% of the amount of the pass-through payment or directed payment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each 30-day period thereafter. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section shall not be reduced as a consequence of payments made under this subsection. The Department shall publish and maintain on its website for a period of no less than 8 calendar quarters, the quarterly calculation of directed payments and pass-through payments owed to each hospital from each MCO. All calculations and reports shall be posted no later than the first day of the quarter for which the payments are to be issued.

(f)(1) For purposes of allocating the funds included in capitation payments to MCOs, Illinois hospitals shall be divided into the following classes as defined in administrative rules:

(A) Critical access hospitals.

(B) Safety-net hospitals, except that stand-alone children's hospitals that are not specialty children's hospitals will not be included.

(C) Long term acute care hospitals.

(D) Freestanding psychiatric hospitals.

(E) Freestanding rehabilitation hospitals.

(F) High Medicaid hospitals. As used in this Section,

"high Medicaid hospital" means a general acute care hospital that is not a safety-net hospital or critical access hospital and that has a Medicaid Inpatient Utilization Rate above 30% or a hospital that had over 35,000 inpatient Medicaid days during the applicable period. For the period July 1, 2020 through December 31, 2020, the applicable period for the Medicaid Inpatient Utilization Rate (MIUR) is the rate year 2020 MIUR and for the number of inpatient days it is State fiscal year 2018. Beginning in calendar year 2021, the Department shall use the most recently determined MIUR, as defined in subsection (h) of Section 5-5.02, and for the inpatient day threshold, the State fiscal year ending 18 months prior to the beginning of the calendar year. For purposes of calculating MIUR under this Section, children's hospitals and affiliated general acute care hospitals shall be considered a single hospital.

(G) General acute care hospitals. As used under this Section, "general acute care hospitals" means all other Illinois hospitals not identified in subparagraphs (A) through (F).

(2) Hospitals' qualification for each class shall be assessed prior to the beginning of each calendar year and the new class designation shall be effective January 1 of the next year. The Department shall publish by rule the process for establishing class determination.

(g) Fixed pool directed payments. Beginning July 1, 2020, the Department shall issue payments to MCOs which shall be used to issue directed payments to qualified Illinois safety-net hospitals and critical access hospitals on a monthly basis in accordance with this subsection. Prior to the beginning of each Payout Quarter beginning July 1, 2020, the Department shall use encounter claims data from the Determination Quarter, accepted by the Department's Medicaid Management Information System for inpatient and outpatient services rendered by safety-net hospitals and critical access hospitals to determine a quarterly uniform per unit add-on for each hospital class.

(1) Inpatient per unit add-on. A quarterly uniform per diem add-on shall be derived by dividing the quarterly Inpatient Directed Payments Pool amount allocated to the applicable hospital class by the total inpatient days contained on all encounter claims received during the Determination Quarter, for all hospitals in the class.

(A) Each hospital in the class shall have a quarterly inpatient directed payment calculated that is equal to the product of the number of inpatient days attributable to the hospital used in the calculation of the quarterly uniform class per diem add-on, multiplied by the calculated applicable quarterly uniform class per diem add-on of the hospital class.

(B) Each hospital shall be paid 1/3 of its quarterly inpatient directed payment in each of the 3

months of the Payout Quarter, in accordance with directions provided to each MCO by the Department.

(2) Outpatient per unit add-on. A quarterly uniform per claim add-on shall be derived by dividing the quarterly Outpatient Directed Payments Pool amount allocated to the applicable hospital class by the total outpatient encounter claims received during the Determination Quarter, for all hospitals in the class.

(A) Each hospital in the class shall have a quarterly outpatient directed payment calculated that is equal to the product of the number of outpatient encounter claims attributable to the hospital used in the calculation of the quarterly uniform class per claim add-on, multiplied by the calculated applicable quarterly uniform class per claim add-on of the hospital class.

(B) Each hospital shall be paid 1/3 of its quarterly outpatient directed payment in each of the 3 months of the Payout Quarter, in accordance with directions provided to each MCO by the Department.

(3) Each MCO shall pay each hospital the Monthly Directed Payment as identified by the Department on its quarterly determination report.

(4) Definitions. As used in this subsection:

(A) "Payout Quarter" means each 3 month calendar quarter, beginning July 1, 2020.

(B) "Determination Quarter" means each 3 month calendar quarter, which ends 3 months prior to the first day of each Payout Quarter.

(5) For the period July 1, 2020 through December 2020, the following amounts shall be allocated to the following hospital class directed payment pools for the quarterly development of a uniform per unit add-on:

(A) $2,894,500 for hospital inpatient services for critical access hospitals.

(B) $4,294,374 for hospital outpatient services for critical access hospitals.

(C) $29,109,330 for hospital inpatient services for safety-net hospitals.

(D) $35,041,218 for hospital outpatient services for safety-net hospitals.

(h) Fixed rate directed payments. Effective July 1, 2020, the Department shall issue payments to MCOs which shall be used to issue directed payments to Illinois hospitals not identified in paragraph (g) on a monthly basis. Prior to the beginning of each Payout Quarter beginning July 1, 2020, the Department shall use encounter claims data from the Determination Quarter, accepted by the Department's Medicaid Management Information System for inpatient and outpatient services rendered by hospitals in each hospital class identified in paragraph (f) and not identified in paragraph (g). For the period July 1, 2020 through December 2020, the Department shall direct MCOs to

make payments as follows:

(1) For general acute care hospitals an amount equal to $1,750 multiplied by the hospital's category of service 20 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 20 for the determination quarter.

(2) For general acute care hospitals an amount equal to $160 multiplied by the hospital's category of service 21 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 21 for the determination quarter.

(3) For general acute care hospitals an amount equal to $80 multiplied by the hospital's category of service 22 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 22 for the determination quarter.

(4) For general acute care hospitals an amount equal to $375 multiplied by the hospital's category of service 24 case mix index for the determination quarter multiplied by the hospital's total number of category of service 24 paid EAPG (EAPGs) for the determination quarter.

(5) For general acute care hospitals an amount equal to $240 multiplied by the hospital's category of service 27 and 28 case mix index for the determination quarter multiplied by the hospital's total number of category of service 27 and 28 paid EAPGs for the determination quarter.

(6) For general acute care hospitals an amount equal to $290 multiplied by the hospital's category of service 29 case mix index for the determination quarter multiplied by the hospital's total number of category of service 29 paid EAPGs for the determination quarter.

(7) For high Medicaid hospitals an amount equal to $1,800 multiplied by the hospital's category of service 20 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 20 for the determination quarter.

(8) For high Medicaid hospitals an amount equal to $160 multiplied by the hospital's category of service 21 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 21 for the determination quarter.

(9) For high Medicaid hospitals an amount equal to $80 multiplied by the hospital's category of service 22 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 22 for the determination quarter.

(10) For high Medicaid hospitals an amount equal to $400 multiplied by the hospital's category of service 24 case mix index for the determination quarter multiplied by the hospital's total number of category of service 24 paid EAPG outpatient claims for the determination quarter.

(11) For high Medicaid hospitals an amount equal to

$240 multiplied by the hospital's category of service 27 and 28 case mix index for the determination quarter multiplied by the hospital's total number of category of service 27 and 28 paid EAPGs for the determination quarter.

(12) For high Medicaid hospitals an amount equal to $290 multiplied by the hospital's category of service 29 case mix index for the determination quarter multiplied by the hospital's total number of category of service 29 paid EAPGs for the determination quarter.

(13) For long term acute care hospitals the amount of $495 multiplied by the hospital's total number of inpatient days for the determination quarter.

(14) For psychiatric hospitals the amount of $210 multiplied by the hospital's total number of inpatient days for category of service 21 for the determination quarter.

(15) For psychiatric hospitals the amount of $250 multiplied by the hospital's total number of outpatient claims for category of service 27 and 28 for the determination quarter.

(16) For rehabilitation hospitals the amount of $410 multiplied by the hospital's total number of inpatient days for category of service 22 for the determination quarter.

(17) For rehabilitation hospitals the amount of $100 multiplied by the hospital's total number of outpatient claims for category of service 29 for the determination quarter.

(18) Each hospital shall be paid 1/3 of their quarterly inpatient and outpatient directed payment in each of the 3 months of the Payout Quarter, in accordance with directions provided to each MCO by the Department.

(19) Each MCO shall pay each hospital the Monthly Directed Payment amount as identified by the Department on its quarterly determination report.

Notwithstanding any other provision of this subsection, if the Department determines that the actual total hospital utilization data that is used to calculate the fixed rate directed payments is substantially different than anticipated when the rates in this subsection were initially determined (for unforeseeable circumstances such as the COVID-19 pandemic), the Department may adjust the rates specified in this subsection so that the total directed payments approximate the total spending amount anticipated when the rates were initially established.

Definitions. As used in this subsection:

(A) "Payout Quarter" means each calendar quarter, beginning July 1, 2020.

(B) "Determination Quarter" means each calendar quarter which ends 3 months prior to the first day of each Payout Quarter.

(C) "Case mix index" means a hospital specific calculation. For inpatient claims the case mix index is calculated each quarter by summing the relative weight

of all inpatient Diagnosis-Related Group (DRG) claims for a category of service in the applicable Determination Quarter and dividing the sum by the number of sum total of all inpatient DRG admissions for the category of service for the associated claims. The case mix index for outpatient claims is calculated each quarter by summing the relative weight of all paid EAPGs in the applicable Determination Quarter and dividing the sum by the sum total of paid EAPGs for the associated claims.

(i) Beginning January 1, 2021, the rates for directed payments shall be recalculated in order to spend the additional funds for directed payments that result from reduction in the amount of pass-through payments allowed under federal regulations. The additional funds for directed payments shall be allocated proportionally to each class of hospitals based on that class' proportion of services.

(j) Pass-through payments.

(1) For the period July 1, 2020 through December 31, 2020, the Department shall assign quarterly pass-through payments to each class of hospitals equal to one-fourth of the following annual allocations:

(A) $390,487,095 to safety-net hospitals.

(B) $62,553,886 to critical access hospitals.

(C) $345,021,438 to high Medicaid hospitals.

(D) $551,429,071 to general acute care hospitals.

(E) $27,283,870 to long term acute care hospitals.

(F) $40,825,444 to freestanding psychiatric hospitals.

(G) $9,652,108 to freestanding rehabilitation hospitals.

(2) The pass-through payments shall at a minimum ensure hospitals receive a total amount of monthly payments under this Section as received in calendar year 2019 in accordance with this Article and paragraph (1) of subsection (d-5) of Section 14-12, exclusive of amounts received through payments referenced in subsection (b).

(3) For the calendar year beginning January 1, 2021, and each calendar year thereafter, each hospital's pass-through payment amount shall be reduced proportionally to the reduction of all pass-through payments required by federal regulations.

(k) At least 30 days prior to each calendar year, the Department shall notify each hospital of changes to the payment methodologies in this Section, including, but not limited to, changes in the fixed rate directed payment rates, the aggregate pass-through payment amount for all hospitals, and the hospital's pass-through payment amount for the upcoming calendar year.

(l) Notwithstanding any other provisions of this Section, the Department may adopt rules to change the methodology for directed and pass-through payments as set forth in this

Section, but only to the extent necessary to obtain federal approval of a necessary State Plan amendment or Directed Payment Preprint or to otherwise conform to federal law or federal regulation.

(m) As used in this subsection, "managed care organization" or "MCO" means an entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis, excluding contracted entities for dual eligible or Department of Children and Family Services youth populations.

(n) In order to address the escalating infant mortality rates among minority communities in Illinois, the State shall, subject to appropriation, create a pool of funding of at least $50,000,000 annually to be dispersed among community safety-net hospitals that maintain perinatal designation from the Department of Public Health. The funding shall be used to preserve or enhance OB/GYN services or other specialty services at the receiving hospital.

(Source: P.A. 101-650, eff. 7-7-20.)

Article 110.

Section 110-1. Short title. This Article may be cited as the Racial Impact Note Act.

Section 110-5. Racial impact note.

(a) Every bill which has or could have a disparate impact on racial and ethnic minorities, upon the request of any member, shall have prepared for it, before second reading in the house of introduction, a brief explanatory statement or note that shall include a reliable estimate of the anticipated impact on those racial and ethnic minorities likely to be impacted by the bill. Each racial impact note must include, for racial and ethnic minorities for which data are available: (i) an estimate of how the proposed legislation would impact racial and ethnic minorities; (ii) a statement of the methodologies and assumptions used in preparing the estimate; (iii) an estimate of the racial and ethnic composition of the population who may be impacted by the proposed legislation, including those persons who may be negatively impacted and those persons who may benefit from the proposed legislation; and (iv) any other matter that a responding agency considers appropriate in relation to the racial and ethnic minorities likely to be affected by the bill.

Section 110-10. Preparation.

(a) The sponsor of each bill for which a request under Section 110-5 has been made shall present a copy of the bill with the request for a racial impact note to the appropriate responding agency or agencies under subsection (b). The responding agency or agencies shall prepare and submit the note to the sponsor of the bill within 5 calendar days, except that

whenever, because of the complexity of the measure, additional time is required for the preparation of the racial impact note, the responding agency or agencies may inform the sponsor of the bill, and the sponsor may approve an extension of the time within which the note is to be submitted, not to extend, however, beyond June 15, following the date of the request. If, in the opinion of the responding agency or agencies, there is insufficient information to prepare a reliable estimate of the anticipated impact, a statement to that effect can be filed and shall meet the requirements of this Act.

(b) If a bill concerns arrests, convictions, or law enforcement, a statement shall be prepared by the Illinois Criminal Justice Information Authority specifying the impact on racial and ethnic minorities. If a bill concerns corrections, sentencing, or the placement of individuals within the Department of Corrections, a statement shall be prepared by the Department of Corrections specifying the impact on racial and ethnic minorities. If a bill concerns local government, a statement shall be prepared by the Department of Commerce and Economic Opportunity specifying the impact on racial and ethnic minorities. If a bill concerns education, one of the following agencies shall prepare a statement specifying the impact on racial and ethnic minorities: (i) the Illinois Community College Board, if the bill affects community colleges; (ii) the Illinois State Board of Education, if the bill affects primary and secondary education; or (iii) the

Illinois Board of Higher Education, if the bill affects State universities. Any other State agency impacted or responsible for implementing all or part of this bill shall prepare a statement of the racial and ethnic impact of the bill as it relates to that agency.

Section 110-15. Requisites and contents. The note shall be factual in nature, as brief and concise as may be, and, in addition, it shall include both the immediate effect and, if determinable or reasonably foreseeable, the long range effect of the measure on racial and ethnic minorities. If, after careful investigation, it is determined that such an effect is not ascertainable, the note shall contain a statement to that effect, setting forth the reasons why no ascertainable effect can be given.

Section 110-20. Comment or opinion; technical or mechanical defects. No comment or opinion shall be included in the racial impact note with regard to the merits of the measure for which the racial impact note is prepared; however, technical or mechanical defects may be noted.

Section 110-25. Appearance of State officials and employees in support or opposition of measure. The fact that a racial impact note is prepared for any bill shall not preclude or restrict the appearance before any committee of the General

Assembly of any official or authorized employee of the responding agency or agencies, or any other impacted State agency, who desires to be heard in support of or in opposition to the measure.

Article 115.

Section 115-5. The Department of Healthcare and Family Services Law of the Civil Administrative Code of Illinois is amended by adding Section 2205-35 as follows:

(20 ILCS 2205/2205-35 new)

Sec. 2205-35. Increasing access to primary care in hospitals. The Department of Healthcare and Family Services shall develop a program to increase the presence of Federally Qualified Health Centers (FQHCs) in hospitals, including, but not limited to, safety-net hospitals, with the goal of increasing care coordination, managing chronic diseases, and addressing the social determinants of health on or before December 31, 2021. In addition, the Department shall develop a payment methodology to allow FQHCs to provide care coordination services, including, but not limited to, chronic disease management and behavioral health services. The Department of Healthcare and Family Services shall develop a payment methodology to allow for care coordination services in FQHCs by no later than December 31, 2021.

Article 120.

Section 120-5. The Civil Administrative Code of Illinois is amended by changing Section 5-565 as follows:

(20 ILCS 5/5-565) (was 20 ILCS 5/6.06)

Sec. 5-565. In the Department of Public Health.

(a) The General Assembly declares it to be the public policy of this State that all residents ~~citizens~~ of Illinois are entitled to lead healthy lives. Governmental public health has a specific responsibility to ensure that a public health system is in place to allow the public health mission to be achieved. The public health system is the collection of public, private, and voluntary entities as well as individuals and informal associations that contribute to the public's health within the State. To develop a public health system requires certain core functions to be performed by government. The State Board of Health is to assume the leadership role in advising the Director in meeting the following functions:

(1) Needs assessment.

(2) Statewide health objectives.

(3) Policy development.

(4) Assurance of access to necessary services.

There shall be a State Board of Health composed of 20 persons, all of whom shall be appointed by the Governor, with

the advice and consent of the Senate for those appointed by the Governor on and after June 30, 1998, and one of whom shall be a senior citizen age 60 or over. Five members shall be physicians licensed to practice medicine in all its branches, one representing a medical school faculty, one who is board certified in preventive medicine, and one who is engaged in private practice. One member shall be a chiropractic physician. One member shall be a dentist; one an environmental health practitioner; one a local public health administrator; one a local board of health member; one a registered nurse; one a physical therapist; one an optometrist; one a veterinarian; one a public health academician; one a health care industry representative; one a representative of the business community; one a representative of the non-profit public interest community; and 2 shall be citizens at large.

The terms of Board of Health members shall be 3 years, except that members shall continue to serve on the Board of Health until a replacement is appointed. Upon the effective date of Public Act 93-975 (January 1, 2005) ~~this amendatory Act of the 93rd General Assembly~~, in the appointment of the Board of Health members appointed to vacancies or positions with terms expiring on or before December 31, 2004, the Governor shall appoint up to 6 members to serve for terms of 3 years; up to 6 members to serve for terms of 2 years; and up to 5 members to serve for a term of one year, so that the term of no more than 6 members expire in the same year. All members shall be

legal residents of the State of Illinois. The duties of the Board shall include, but not be limited to, the following:

(1) To advise the Department of ways to encourage public understanding and support of the Department's programs.

(2) To evaluate all boards, councils, committees, authorities, and bodies advisory to, or an adjunct of, the Department of Public Health or its Director for the purpose of recommending to the Director one or more of the following:

(i) The elimination of bodies whose activities are not consistent with goals and objectives of the Department.

(ii) The consolidation of bodies whose activities encompass compatible programmatic subjects.

(iii) The restructuring of the relationship between the various bodies and their integration within the organizational structure of the Department.

(iv) The establishment of new bodies deemed essential to the functioning of the Department.

(3) To serve as an advisory group to the Director for public health emergencies and control of health hazards.

(4) To advise the Director regarding public health policy, and to make health policy recommendations regarding priorities to the Governor through the Director.

(5) To present public health issues to the Director and

to make recommendations for the resolution of those issues.

(6) To recommend studies to delineate public health problems.

(7) To make recommendations to the Governor through the Director regarding the coordination of State public health activities with other State and local public health agencies and organizations.

(8) To report on or before February 1 of each year on the health of the residents of Illinois to the Governor, the General Assembly, and the public.

(9) To review the final draft of all proposed administrative rules, other than emergency or peremptory ~~preemptory~~ rules and those rules that another advisory body must approve or review within a statutorily defined time period, of the Department after September 19, 1991 (the effective date of Public Act 87-633). The Board shall review the proposed rules within 90 days of submission by the Department. The Department shall take into consideration any comments and recommendations of the Board regarding the proposed rules prior to submission to the Secretary of State for initial publication. If the Department disagrees with the recommendations of the Board, it shall submit a written response outlining the reasons for not accepting the recommendations.

In the case of proposed administrative rules or amendments to administrative rules regarding immunization

of children against preventable communicable diseases designated by the Director under the Communicable Disease Prevention Act, after the Immunization Advisory Committee has made its recommendations, the Board shall conduct 3 public hearings, geographically distributed throughout the State. At the conclusion of the hearings, the State Board of Health shall issue a report, including its recommendations, to the Director. The Director shall take into consideration any comments or recommendations made by the Board based on these hearings.

(10) To deliver to the Governor for presentation to the General Assembly a State Health Assessment (SHA) and a State Health Improvement Plan (SHIP). The first 5 ~~3~~ such plans shall be delivered to the Governor on January 1, 2006, January 1, 2009, ~~and~~ January 1, 2016, January 1, 2021, and June 30, 2022, and then every 5 years thereafter.

The State Health Assessment and State Health Improvement Plan ~~Plan~~ shall assess and recommend priorities and strategies to improve the public health system, ~~and~~ the health status of Illinois residents, reduce health disparities and inequities, and promote health equity. The State Health Assessment and State Health Improvement Plan development and implementation shall conform to national Public Health Accreditation Board Standards. The State Health Assessment and State Health Improvement Plan development and implementation process

shall be carried out with the administrative and operational support of the Department of Public Health ~~taking into consideration national health objectives and system standards as frameworks for assessment~~.

The State Health Assessment shall include comprehensive, broad-based data and information from a variety of sources on health status and the public health system including:

(i) quantitative data on the demographics and health status of the population, including data over time on health by gender, sex, race, ethnicity, age, socio-economic factors, geographic region, and other indicators of disparity;

(ii) quantitative data on social and structural issues affecting health (social and structural determinants of health), including, but not limited to, housing, transportation, educational attainment, employment, and income inequality;

(iii) priorities and strategies developed at the community level through the Illinois Project for Local Assessment of Needs (IPLAN) and other local and regional community health needs assessments;

(iv) qualitative data representing the population's input on health concerns and well-being, including the perceptions of people experiencing disparities and health inequities;

(v) information on health disparities and health inequities; and

(vi) information on public health system strengths and areas for improvement.

~~The Plan shall also take into consideration priorities and strategies developed at the community level through the Illinois Project for Local Assessment of Needs (IPLAN) and any regional health improvement plans that may be developed.~~

The State Health Improvement Plan ~~Plan~~ shall focus on prevention, social determinants of health, and promoting health equity as key strategies ~~as a key strategy~~ for long-term health improvement in Illinois.

The State Health Improvement Plan ~~Plan~~ shall identify priority State health issues and social issues affecting health, and shall examine and make recommendations on the contributions and strategies of the public and private sectors for improving health status and the public health system in the State. In addition to recommendations on health status improvement priorities and strategies for the population of the State as a whole, the State Health Improvement Plan ~~Plan~~ shall make recommendations regarding priorities and strategies for reducing and eliminating health disparities and health inequities in Illinois; including racial, ethnic, gender, sex, age, socio-economic, and geographic disparities. The State

Health Improvement Plan shall make recommendations regarding social determinants of health, such as housing, transportation, educational attainment, employment, and income inequality.

The development and implementation of the State Health Assessment and State Health Improvement Plan shall be a collaborative public-private cross-agency effort overseen by the SHA and SHIP Partnership. The Director of Public Health shall consult with the Governor to ensure participation by the head of State agencies with public health responsibilities (or their designees) in the SHA and SHIP Partnership, including, but not limited to, the Department of Public Health, the Department of Human Services, the Department of Healthcare and Family Services, the Department of Children and Family Services, the Environmental Protection Agency, the Illinois State Board of Education, the Department on Aging, the Illinois Housing Development Authority, the Illinois Criminal Justice Information Authority, the Department of Agriculture, the Department of Transportation, the Department of Corrections, the Department of Commerce and Economic Opportunity, and the Chair of the State Board of Health to also serve on the Partnership. A member of the Governors' staff shall participate in the Partnership and serve as a liaison to the Governors' office.

The Director of ~~the Illinois Department of~~ Public

Health shall appoint a minimum of 20 other members of the SHA and SHIP Partnership representing ~~a Planning Team that includes~~ a range of public, private, and voluntary sector stakeholders and participants in the public health system. For the first SHA and SHIP Partnership after the effective date of this amendatory Act of the 101st General Assembly, one-half of the members shall be appointed for a 3-year term, and one-half of the members shall be appointed for a 5-year term. Subsequently, members shall be appointed to 5-year terms. Should any member not be able to fulfill his or her term, the Director may appoint a replacement to complete that term. The Director, in consultation with the SHA and SHIP Partnership, may engage additional individuals and organizations to serve on subcommittees and ad hoc efforts to conduct the State Health Assessment and develop and implement the State Health Improvement Plan. Members of the SHA and SHIP Partnership shall receive no compensation for serving as members, but may be reimbursed for their necessary expenses.

The SHA and SHIP Partnership ~~This Team~~ shall include: ~~the directors of State agencies with public health responsibilities (or their designees), including but not limited to the Illinois Departments of Public Health and Department of Human Services,~~ representatives of local health departments~~, representatives of local community health partnerships,~~ and individuals with expertise who

represent an array of organizations and constituencies engaged in public health improvement and prevention, such as non-profit public interest groups, groups serving populations that experience health disparities and health inequities, groups addressing social determinants of health, health issue groups, faith community groups, health care providers, businesses and employers, academic institutions, and community-based organizations.

The Director shall endeavor to make the membership of the Partnership diverse and inclusive of the racial, ethnic, gender, socio-economic, and geographic diversity of the State. The SHA and SHIP Partnership shall be chaired by the Director of Public Health or his or her designee.

The SHA and SHIP Partnership shall develop and implement a community engagement process that facilitates input into the development of the State Health Assessment and State Health Improvement Plan. This engagement process shall ensure that individuals with lived experience in the issues addressed in the State Health Assessment and State Health Improvement Plan are meaningfully engaged in the development and implementation of the State Health Assessment and State Health Improvement Plan.

The State Board of Health shall hold at least 3 public hearings addressing a draft of the State Health Improvement Plan ~~drafts of the Plan~~ in representative geographic areas of the State. ~~Members of the Planning Team shall receive no~~

~~compensation for their services, but may be reimbursed for their necessary expenses.~~

~~Upon the delivery of each State Health Improvement Plan, the Governor shall appoint a SHIP Implementation Coordination Council that includes a range of public, private, and voluntary sector stakeholders and participants in the public health system. The Council shall include the directors of State agencies and entities with public health system responsibilities (or their designees), including but not limited to the Department of Public Health, Department of Human Services, Department of Healthcare and Family Services, Environmental Protection Agency, Illinois State Board of Education, Department on Aging, Illinois Violence Prevention Authority, Department of Agriculture, Department of Insurance, Department of Financial and Professional Regulation, Department of Transportation, and Department of Commerce and Economic Opportunity and the Chair of the State Board of Health. The Council shall include representatives of local health departments and individuals with expertise who represent an array of organizations and constituencies engaged in public health improvement and prevention, including non-profit public interest groups, health issue groups, faith community groups, health care providers, businesses and employers, academic institutions, and community based organizations. The Governor shall endeavor to make the~~

~~membership of the Council representative of the racial, ethnic, gender, socio-economic, and geographic diversity of the State. The Governor shall designate one State agency representative and one other non-governmental member as co-chairs of the Council. The Governor shall designate a member of the Governor's office to serve as liaison to the Council and one or more State agencies to provide or arrange for support to the Council. The members of the SHIP Implementation Coordination Council for each State Health Improvement Plan shall serve until the delivery of the subsequent State Health Improvement Plan, whereupon a new Council shall be appointed. Members of the SHIP Planning Team may serve on the SHIP Implementation Coordination Council if so appointed by the Governor.~~

Upon the delivery of each State Health Assessment and State Health Improvement Plan, the SHA and SHIP Partnership ~~The SHIP Implementation Coordination Council~~ shall coordinate the efforts and engagement of the public, private, and voluntary sector stakeholders and participants in the public health system to implement each SHIP. The Partnership ~~Council~~ shall serve as a forum for collaborative action; coordinate existing and new initiatives; develop detailed implementation steps, with mechanisms for action; implement specific projects; identify public and private funding sources at the local, State and federal level; promote public awareness of the

SHIP; and advocate for the implementation of the SHIP. The SHA and SHIP Partnership shall implement strategies to ensure that individuals and communities affected by health disparities and health inequities are engaged in the process throughout the 5-year cycle. The SHA and SHIP Partnership shall not have the authority to direct any public or private entity to take specific action to implement the SHIP. ~~; and develop an annual report to the Governor, General Assembly, and public regarding the status of implementation of the SHIP. The Council shall not, however, have the authority to direct any public or private entity to take specific action to implement the SHIP.~~

The SHA and SHIP Partnership shall regularly evaluate and update the State Health Assessment and track implementation of the State Health Improvement Plan with revisions as necessary. The State Board of Health shall submit a report by January 31 of each year on the status of State Health Improvement Plan implementation and community engagement activities to the Governor, General Assembly, and public. In the fifth year, the report may be consolidated into the new State Health Assessment and State Health Improvement Plan.

(11) Upon the request of the Governor, to recommend to the Governor candidates for Director of Public Health when vacancies occur in the position.

(12) To adopt bylaws for the conduct of its own business, including the authority to establish ad hoc committees to address specific public health programs requiring resolution.

(13) (Blank).

Upon appointment, the Board shall elect a chairperson from among its members.

Members of the Board shall receive compensation for their services at the rate of $150 per day, not to exceed $10,000 per year, as designated by the Director for each day required for transacting the business of the Board and shall be reimbursed for necessary expenses incurred in the performance of their duties. The Board shall meet from time to time at the call of the Department, at the call of the chairperson, or upon the request of 3 of its members, but shall not meet less than 4 times per year.

(b) (Blank).

(c) An Advisory Board on Necropsy Service to Coroners, which shall counsel and advise with the Director on the administration of the Autopsy Act. The Advisory Board shall consist of 11 members, including a senior citizen age 60 or over, appointed by the Governor, one of whom shall be designated as chairman by a majority of the members of the Board. In the appointment of the first Board the Governor shall appoint 3 members to serve for terms of 1 year, 3 for terms of 2 years, and 3 for terms of 3 years. The members first appointed

under Public Act 83-1538 shall serve for a term of 3 years. All members appointed thereafter shall be appointed for terms of 3 years, except that when an appointment is made to fill a vacancy, the appointment shall be for the remaining term of the position vacant. The members of the Board shall be citizens of the State of Illinois. In the appointment of members of the Advisory Board the Governor shall appoint 3 members who shall be persons licensed to practice medicine and surgery in the State of Illinois, at least 2 of whom shall have received post-graduate training in the field of pathology; 3 members who are duly elected coroners in this State; and 5 members who shall have interest and abilities in the field of forensic medicine but who shall be neither persons licensed to practice any branch of medicine in this State nor coroners. In the appointment of medical and coroner members of the Board, the Governor shall invite nominations from recognized medical and coroners organizations in this State respectively. Board members, while serving on business of the Board, shall receive actual necessary travel and subsistence expenses while so serving away from their places of residence.

(Source: P.A. 98-463, eff. 8-16-13; 99-527, eff. 1-1-17; revised 7-17-19.)

## Article 125.

Section 125-1. Short title. This Article may be cited as

the Health and Human Services Task Force and Study Act. References in this Article to "this Act" mean this Article.

Section 125-5. Findings. The General Assembly finds that:

(1) The State is committed to improving the health and well-being of Illinois residents and families.

(2) According to data collected by the Kaiser Foundation, Illinois had over 905,000 uninsured residents in 2019, with a total uninsured rate of 7.3%.

(3) Many Illinois residents and families who have health insurance cannot afford to use it due to high deductibles and cost sharing.

(4) Lack of access to affordable health care services disproportionately affects minority communities throughout the State, leading to poorer health outcomes among those populations.

(5) Illinois Medicaid beneficiaries are not receiving the coordinated and effective care they need to support their overall health and well-being.

(6) Illinois has an opportunity to improve the health and well-being of a historically underserved and vulnerable population by providing more coordinated and higher quality care to its Medicaid beneficiaries.

(7) The State of Illinois has a responsibility to help crime victims access justice, assistance, and the support they need to heal.

(8) Research has shown that people who are repeatedly victimized are more likely to face mental health problems such as depression, anxiety, and symptoms related to post-traumatic stress disorder and chronic trauma.

(9) Trauma-informed care has been promoted and established in communities across the country on a bipartisan basis, and numerous federal agencies have integrated trauma-informed approaches into their programs and grants, which should be leveraged by the State of Illinois.

(10) Infants, children, and youth and their families who have experienced or are at risk of experiencing trauma, including those who are low-income, homeless, involved with the child welfare system, involved in the juvenile or adult justice system, unemployed, or not enrolled in or at risk of dropping out of an educational institution and live in a community that has faced acute or long-term exposure to substantial discrimination, historical oppression, intergenerational poverty, a high rate of violence or drug overdose deaths, should have an opportunity for improved outcomes; this means increasing access to greater opportunities to meet educational, employment, health, developmental, community reentry, permanency from foster care, or other key goals.

Section 125-10. Health and Human Services Task Force. The

Health and Human Services Task Force is created within the Department of Human Services to undertake a systematic review of health and human service departments and programs with the goal of improving health and human service outcomes for Illinois residents.

Section 125-15. Study.

(1) The Task Force shall review all health and human service departments and programs and make recommendations for achieving a system that will improve interagency interoperability with respect to improving access to healthcare, healthcare disparities, workforce competency and diversity, social determinants of health, and data sharing and collection. These recommendations shall include, but are not limited to, the following elements:

(i) impact on infant and maternal mortality;

(ii) impact of hospital closures, including safety-net hospitals, on local communities; and

(iii) impact on Medicaid Managed Care Organizations.

(2) The Task Force shall review and make recommendations on ways the Medicaid program can partner and cooperate with other agencies, including but not limited to the Department of Agriculture, the Department of Insurance, the Department of Human Services, the Department of Labor, the Environmental Protection Agency, and the Department of Public Health, to better address social determinants of public health,

including, but not limited to, food deserts, affordable housing, environmental pollutions, employment, education, and public support services. This shall include a review and recommendations on ways Medicaid and the agencies can share costs related to better health outcomes.

(3) The Task Force shall review the current partnership, communication, and cooperation between Federally Qualified Health Centers (FQHCs) and safety-net hospitals in Illinois and make recommendations on public policies that will improve interoperability and cooperations between these entities in order to achieve improved coordinated care and better health outcomes for vulnerable populations in the State.

(4) The Task Force shall review and examine public policies affecting trauma and social determinants of health, including trauma-informed care, and make recommendations on ways to improve and integrate trauma-informed approaches into programs and agencies in the State, including, but not limited to, Medicaid and other health care programs administered by the State, and increase awareness of trauma and its effects on communities across Illinois.

(5) The Task Force shall review and examine the connection between access to education and health outcomes particularly in African American and minority communities and make recommendations on public policies to address any gaps or deficiencies.

Section 125-20. Membership; appointments; meetings; support.

(1) The Task Force shall include representation from both public and private organizations, and its membership shall reflect regional, racial, and cultural diversity to ensure representation of the needs of all Illinois citizens. Task Force members shall include one member appointed by the President of the Senate, one member appointed by the Minority Leader of the Senate, one member appointed by the Speaker of the House of Representatives, one member appointed by the Minority Leader of the House of Representatives, and other members appointed by the Governor. The Governor's appointments shall include, without limitation, the following:

(A) One member of the Senate, appointed by the Senate President, who shall serve as Co-Chair;

(B) One member of the House of Representatives, appointed by the Speaker of the House, who shall serve as Co-Chair;

(C) Eight members of the General Assembly representing each of the majority and minority caucuses of each chamber.

(D) The Directors or Secretaries of the following State agencies or their designees:

(i) Department of Human Services.

(ii) Department of Children and Family Services.

(iii) Department of Healthcare and Family Services.

(iv) State Board of Education.

(v) Department on Aging.

(vi) Department of Public Health.

(vii) Department of Veterans' Affairs.

(viii) Department of Insurance.

(E) Local government stakeholders and nongovernmental stakeholders with an interest in human services, including representation among the following private-sector fields and constituencies:

(i) Early childhood education and development.

(ii) Child care.

(iii) Child welfare.

(iv) Youth services.

(v) Developmental disabilities.

(vi) Mental health.

(vii) Employment and training.

(viii) Sexual and domestic violence.

(ix) Alcohol and substance abuse.

(x) Local community collaborations among human services programs.

(xi) Immigrant services.

(xii) Affordable housing.

(xiii) Food and nutrition.

(xiv) Homelessness.

(xv) Older adults.

(xvi) Physical disabilities.

(xvii) Maternal and child health.

(xviii) Medicaid managed care organizations.

(xix) Healthcare delivery.

(xx) Health insurance.

(2) Members shall serve without compensation for the duration of the Task Force.

(3) In the event of a vacancy, the appointment to fill the vacancy shall be made in the same manner as the original appointment.

(4) The Task Force shall convene within 60 days after the effective date of this Act. The initial meeting of the Task Force shall be convened by the co-chair selected by the Governor. Subsequent meetings shall convene at the call of the co-chairs. The Task Force shall meet on a quarterly basis, or more often if necessary.

(5) The Department of Human Services shall provide administrative support to the Task Force.

Section 125-25. Report. The Task Force shall report to the Governor and the General Assembly on the Task Force's progress toward its goals and objectives by June 30, 2021, and every June 30 thereafter.

Section 125-30. Transparency. In addition to whatever policies or procedures it may adopt, all operations of the Task Force shall be subject to the provisions of the Freedom of

Information Act and the Open Meetings Act. This Section shall not be construed so as to preclude other State laws from applying to the Task Force and its activities.

Section 125-40. Repeal. This Article is repealed June 30, 2023.

Article 130.

Section 130-1. Short title. This Article may be cited as the Anti-Racism Commission Act. References in this Article to "this Act" mean this Article.

Section 130-5. Findings. The General Assembly finds and declares all of the following:

(1) Public health is the science and art of preventing disease, of protecting and improving the health of people, entire populations, and their communities; this work is achieved by promoting healthy lifestyles and choices, researching disease, and preventing injury.

(2) Public health professionals try to prevent problems from happening or recurring through implementing educational programs, recommending policies, administering services, and limiting health disparities through the promotion of equitable and accessible healthcare.

(3) According to the Centers for Disease Control and

Prevention, racism and segregation in the State of Illinois have exacerbated a health divide, resulting in Black residents having lower life expectancies than white citizens of this State and being far more likely than other races to die prematurely (before the age of 75) and to die of heart disease or stroke; Black residents of Illinois have a higher level of infant mortality, lower birth weight babies, and are more likely to be overweight or obese as adults, have adult diabetes, and have long-term complications from diabetes that exacerbate other conditions, including the susceptibility to COVID-19.

(4) Black and Brown people are more likely to experience poor health outcomes as a consequence of their social determinants of health, health inequities stemming from economic instability, education, physical environment, food, and access to health care systems.

(5) Black residents in Illinois are more likely than white residents to experience violence-related trauma as a result of socioeconomic conditions resulting from systemic racism.

(6) Racism is a social system with multiple dimensions in which individual racism is internalized or interpersonal and systemic racism is institutional or structural and is a system of structuring opportunity and assigning value based on the social interpretation of how one looks; this unfairly disadvantages specific

individuals and communities, while unfairly giving advantages to other individuals and communities; it saps the strength of the whole society through the waste of human resources.

(7) Racism causes persistent racial discrimination that influences many areas of life, including housing, education, employment, and criminal justice; an emerging body of research demonstrates that racism itself is a social determinant of health.

(8) More than 100 studies have linked racism to worse health outcomes.

(9) The American Public Health Association launched a National Campaign against Racism.

(10) Public health's responsibilities to address racism include reshaping our discourse and agenda so that we all actively engage in racial justice work.

Section 130-10. Anti-Racism Commission.

(a) The Anti-Racism Commission is hereby created to identify and propose statewide policies to eliminate systemic racism and advance equitable solutions for Black and Brown people in Illinois.

(b) The Anti-Racism Commission shall consist of the following members, who shall serve without compensation:

(1) one member of the House of Representatives, appointed by the Speaker of the House of Representatives,

who shall serve as co-chair;

(2) one member of the Senate, appointed by the Senate President, who shall serve as co-chair;

(3) one member of the House of Representatives, appointed by the Minority Leader of the House of Representatives;

(4) one member of the Senate, appointed by the Minority Leader of the Senate;

(5) the Director of Public Health, or his or her designee;

(6) the Chair of the House Black Caucus;

(7) the Chair of the Senate Black Caucus;

(8) the Chair of the Joint Legislative Black Caucus;

(9) the director of a statewide association representing public health departments, appointed by the Speaker of the House of Representatives;

(10) the Chair of the House Latino Caucus;

(11) the Chair of the Senate Latino Caucus;

(12) one community member appointed by the House Black Caucus Chair;

(13) one community member appointed by the Senate Black Caucus Chair;

(14) one community member appointed by the House Latino Caucus Chair; and

(15) one community member appointed by the Senate Latino Caucus Chair.

(c) The Department of Public Health shall provide administrative support for the Commission.

(d) The Commission is charged with, but not limited to, the following tasks:

(1) Working to create an equity and justice-oriented State government.

(2) Assessing the policy and procedures of all State agencies to ensure racial equity is a core element of State government.

(3) Developing and incorporating into the organizational structure of State government a plan for educational efforts to understand, address, and dismantle systemic racism in government actions.

(4) Recommending and advocating for policies that improve health in Black and Brown people and support local, State, regional, and federal initiatives that advance efforts to dismantle systemic racism.

(5) Working to build alliances and partnerships with organizations that are confronting racism and encouraging other local, State, regional, and national entities to recognize racism as a public health crisis.

(6) Promoting community engagement, actively engaging citizens on issues of racism and assisting in providing tools to engage actively and authentically with Black and Brown people.

(7) Reviewing all portions of codified State laws

through the lens of racial equity.

(8) Working with the Department of Central Management Services to update policies that encourage diversity in human resources, including hiring, board appointments, and vendor selection by agencies, and to review all grant management activities with an eye toward equity and workforce development.

(9) Recommending policies that promote racially equitable economic and workforce development practices.

(10) Promoting and supporting all policies that prioritize the health of all people, especially people of color, by mitigating exposure to adverse childhood experiences and trauma in childhood and ensuring implementation of health and equity in all policies.

(11) Encouraging community partners and stakeholders in the education, employment, housing, criminal justice, and safety arenas to recognize racism as a public health crisis and to implement policy recommendations.

(12) Identifying clear goals and objectives, including specific benchmarks, to assess progress.

(13) Holding public hearings across Illinois to continue to explore and to recommend needed action by the General Assembly.

(14) Working with the Governor and the General Assembly to identify the necessary funds to support the Anti-Racism Commission and its endeavors.

(15) Identifying resources to allocate to Black and Brown communities on an annual basis.

(16) Encouraging corporate investment in anti-racism policies in Black and Brown communities.

(e) The Commission shall submit its final report to the Governor and the General Assembly no later than December 31, 2021. The Commission is dissolved upon the filing of its report.

Section 130-15. Repeal. This Article is repealed on January 1, 2023.

Article 131.

Section 131-1. Short title. This Article may be cited as the Sickle Cell Prevention, Care, and Treatment Program Act. References in this Article to "this Act" mean this Article.

Section 131-5. Definitions. As used in this Act:

"Department" means the Department of Public Health.

"Program" means the Sickle Cell Prevention, Care, and Treatment Program.

Section 131-10. Sickle Cell Prevention, Care, and Treatment Program. The Department shall establish a grant program for the purpose of providing for the prevention, care,

and treatment of sickle cell disease and for educational programs concerning the disease.

Section 131-15. Grants; eligibility standards.

(a) The Department shall do the following:

(1)(A) Develop application criteria and standards of eligibility for groups or organizations who apply for funds under the program.

(B) Make available grants to groups and organizations who meet the eligibility standards set by the Department. However:

(i) the highest priority for grants shall be accorded to established sickle cell disease community-based organizations throughout Illinois; and

(ii) priority shall also be given to ensuring the establishment of sickle cell disease centers in underserved areas that have a higher population of sickle cell disease patients.

(2) Determine the maximum amount available for each grant provided under subparagraph (B) of paragraph (1).

(3) Determine policies for the expiration and renewal of grants provided under subparagraph (B) of paragraph (1).

(4) Require that all grant funds be used for the purpose of prevention, care, and treatment of sickle cell disease or for educational programs concerning the disease. Grant funds shall be used for one or more of the

following purposes:

(A) Assisting in the development and expansion of care for the treatment of individuals with sickle cell disease, particularly for adults, including the following types of care:

(i) Self-administered care.

(ii) Preventive care.

(iii) Home care.

(iv) Other evidence-based medical procedures and techniques designed to provide maximum control over sickling episodes typical of occurring to an individual with the disease.

(B) Increasing access to health care for individuals with sickle cell disease.

(C) Establishing additional sickle cell disease infusion centers.

(D) Increasing access to mental health resources and pain management therapies for individuals with sickle cell disease.

(E) Providing counseling to any individual, at no cost, concerning sickle cell disease and sickle cell trait, and the characteristics, symptoms, and treatment of the disease.

(i) The counseling described in this subparagraph (E) may consist of any of the following:

(I) Genetic counseling for an individual who tests positive for the sickle cell trait.

(II) Psychosocial counseling for an individual who tests positive for sickle cell disease, including any of the following:

(aa) Social service counseling.

(bb) Psychological counseling.

(cc) Psychiatric counseling.

(5) Develop a sickle cell disease educational outreach program that includes the dissemination of educational materials to the following concerning sickle cell disease and sickle cell trait:

(A) Medical residents.

(B) Immigrants.

(C) Schools and universities.

(6) Adopt any rules necessary to implement the provisions of this Act.

(b) The Department may contract with an entity to implement the sickle cell disease educational outreach program described in paragraph (5) of subsection (a).

Section 131-20. Sickle Cell Chronic Disease Fund.

(a) The Sickle Cell Chronic Disease Fund is created as a special fund in the State treasury for the purpose of carrying out the provisions of this Act and for no other purpose. The Fund shall be administered by the Department.

(b) The Fund shall consist of:

(1) Any moneys appropriated to the Department for the Sickle Cell Prevention, Care, and Treatment Program.

(2) Gifts, bequests, and other sources of funding.

(3) All interest earned on moneys in the Fund.

Section 131-25. Study.

(a) Before July 1, 2022, and on a biennial basis thereafter, the Department, with the assistance of:

(1) the Center for Minority Health Services;

(2) health care providers that treat individuals with sickle cell disease;

(3) individuals diagnosed with sickle cell disease;

(4) representatives of community-based organizations that serve individuals with sickle cell disease; and

(5) data collected via newborn screening for sickle cell disease;

shall perform a study to determine the prevalence, impact, and needs of individuals with sickle cell disease and the sickle cell trait in Illinois.

(b) The study must include the following:

(1) The prevalence, by geographic location, of individuals diagnosed with sickle cell disease in Illinois.

(2) The prevalence, by geographic location, of individuals diagnosed as sickle cell trait carriers in

Illinois.

(3) The availability and affordability of screening services in Illinois for the sickle cell trait.

(4) The location and capacity of the following for the treatment of sickle cell disease and sickle cell trait carriers:

(A) Treatment centers.

(B) Clinics.

(C) Community-based social service organizations.

(D) Medical specialists.

(5) The unmet medical, psychological, and social needs encountered by individuals in Illinois with sickle cell disease.

(6) The underserved areas of Illinois for the treatment of sickle cell disease.

(7) Recommendations for actions to address any shortcomings in the State identified under this Section.

(c) The Department shall submit a report on the study performed under this Section to the General Assembly.

Section 131-30. Implementation subject to appropriation. Implementation of this Act is subject to appropriation.

Section 131-90. The State Finance Act is amended by adding Section 5.936 as follows:

(30 ILCS 105/5.936 new)

Sec. 5.936. The Sickle Cell Chronic Disease Fund.

Article 132.

Section 132-5. The School Code is amended by adding Section 34-18.67 as follows:

(105 ILCS 5/34-18.67 new)

Sec. 34-18.67. School nurse pilot program. The board shall establish a school nurse pilot program. Under the program, the board shall require the top 20% of the lowest performing schools in the district, as determined by the board, to employ a school nurse in conformance with Section 10-22.23 of this Code. The board shall implement this program beginning with the 2021-2022 school year.

Article 133.

Section 133-1. Short title. This Article may be cited as the Health Care for All Illinois Act. References in this Article to "this Act" mean this Article.

Section 133-5. Purposes. It is the purpose of this Act to provide universal access to health care for all individuals within the State, to promote and improve the health of all its

citizens, to stress the importance of good public health through treatment and prevention of diseases, and to contain costs to make the delivery of this care affordable. Should legislation of this kind be enacted on a federal level, it is the intent of this Act to become a part of a nationwide system.

Section 133-10. Definitions. In this Act:

"Board" means the Illinois Health Services Governing Board.

"Program" means the Illinois Health Services Program.

Section 133-15. Eligibility; registration. All individuals residing in this State are covered under the Illinois Health Services Program for health insurance and shall receive a card with a unique number in the mail. An individual's social security number shall not be used for purposes of registration under this Section. Individuals and families shall receive an Illinois Health Services Insurance Card in the mail after filling out a program application form at a health care provider. Such application form shall be no more than 2 pages long. Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to receive an Illinois Health Services Insurance Card and have payment made for such benefits.

Section 133-20. Benefits and portability.

(a) The health coverage benefits under this Act shall cover all medically necessary services, including:

(1) primary care and prevention;

(2) specialty care (other than what is deemed elective cosmetic);

(3) inpatient care;

(4) outpatient care;

(5) emergency care;

(6) prescription drugs;

(7) durable medical equipment;

(8) long-term care;

(9) mental health services;

(10) the full scope of dental services (other than elective cosmetic dentistry);

(11) substance abuse treatment services;

(12) chiropractic services; and

(13) basic vision care and vision correction.

(b) Health coverage benefits under this Act are available through any licensed health care provider anywhere in the State that is legally qualified to provide such benefits and for emergency care anywhere in the United States.

(c) No deductibles, copayments, coinsurance, or other cost sharing shall be imposed with respect to covered benefits except for those goods or services that exceed basic covered benefits, as defined by the Board.

Section 133-25. Qualification of participating providers.

(a) Health care delivery facilities must meet regional and State quality and licensing guidelines as a condition of participation under the program, including guidelines regarding safe staffing and quality of care.

(b) A participating health care provider must be licensed by the State. No health care provider whose license is under suspension or has been revoked may participate in the program.

(c) Only nonprofit health maintenance organizations that actually deliver care in their own facilities and directly employ clinicians may participate in the program.

(d) Patients shall have free choice of participating eligible providers, hospitals, and inpatient care facilities.

Section 133-30. Provider reimbursement.

(a) The program shall pay all health care providers according to the following standards:

(1) Physicians and other practitioners can choose to be paid fee-for-service, salaried by institutions receiving global budgets, or salaried by group practices or health maintenance organizations receiving capitation payments. Investor-owned health maintenance organizations and group practices shall be converted to not-for-profit status. Only institutions that deliver care shall be eligible for program payments.

(2) The program will pay each hospital and providing institution a monthly lump sum (global budget) to cover all operating expenses. The hospital and program will negotiate the amount of this payment annually based on past budgets, clinical performance, projected changes in demand for services and input costs, and proposed new programs. Hospitals shall not bill patients for services covered by the program, and cannot use any of their operating budgets for expansion, profit, excessive executive income, marketing, or major capital purchases or leases.

(3) The program budget will fund major capital expenditures, including the construction of new health facilities and the purchase of expensive equipment. The regional health planning districts shall allocate these capital funds and oversee capital projects funded from private donations.

(b) The program shall reimburse physicians choosing to be paid fee-for-service according to a fee schedule negotiated between physician representatives and the program on at least an annual basis.

(c) Hospitals, nursing homes, community health centers, nonprofit staff model health maintenance organizations, and home health care agencies will receive a global budget to cover operating expenses, negotiated annually with the program based on past expenditures, past budgets, clinical performance, projected changes in demand for services and input costs, and

proposed new programs. Expansions and other substantive capital investments will be funded separately.

(d) All covered prescription drugs and durable medical supplies will be paid for according to a fee schedule negotiated between manufacturers and the program on at least an annual basis. Price reductions shall be achieved by bulk purchasing whenever possible. Where therapeutically equivalent drugs are available, the formulary shall specify the use of the lowest-cost medication, with exceptions available in the case of medical necessity.

Section 133-35. Prohibition against duplicating coverage; investor-ownership of health delivery facilities.

(a) It is unlawful for a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act. Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act.

(b) Investor-ownership of health delivery facilities, including hospitals, health maintenance organizations, nursing homes, and clinics, is unlawful. Investor-owners of health delivery facilities at the time of the effective date of this Act shall be compensated for the loss of their facilities, but not for loss of business opportunities or for administrative capacity not used by the program.

Section 133-40. Illinois Health Services Trust.

(a) The State shall establish the Illinois Health Services Trust (IHST), the sole purpose of which shall be to provide the financing reserve for the purposes outlined in this Act. Specifically, the IHST shall provide all of the following:

(1) The funds for the general operating budget of the program.

(2) Reimbursement for those benefits outlined in Section 133-20 of this Act.

(3) Public health services.

(4) Capital expenditures for construction or renovation of health care facilities or major equipment purchases deemed necessary throughout the State and approved by the Board.

(5) Re-education and job placement of persons who have lost their jobs as a result of this transition, limited to the first 5 years.

(b) The General Assembly or the Governor may provide funds to the IHST, but may not remove or borrow funds from the IHST.

(c) The IHST shall be administered by the Board, under the oversight of the General Assembly.

(d) Funding of the IHST shall include, but is not limited to, all of the following:

(1) Funds appropriated as outlined by the General Assembly on a yearly basis.

(2) A progressive set of graduated income

contributions; 20% paid by individuals, 20% paid by businesses, and 60% paid by the government.

(3) All federal moneys that are designated for health care, including, but not limited to, all moneys designated for Medicaid. The Secretary of Human Services shall be authorized to negotiate with the federal government for funding of Medicare recipients.

(4) Grants and contributions, both public and private.

(5) Any other tax revenues designated by the General Assembly.

(6) Any other funds specifically earmarked for health care or health care education, such as settlements from litigation.

(e) The total overhead and administrative portion of the program budget may not exceed 12% of the total operating budget of the program for the first 2 years that the program is in operation; 8% for the following 2 years; and 5% for each year thereafter.

(f) The program may be divided into regional districts for the purposes of local administration and oversight of programs that are specific to each region's needs.

(g) Claims billing from all providers must be submitted electronically and in compliance with current State and federal privacy laws within 5 years after the effective date of this Act. Electronic claims and billing must be uniform across the State. The Board shall create and implement a statewide uniform

system of electronic medical records that is in compliance with current State and federal privacy laws within 7 years after the effective date of this Act. Payments to providers must be made in a timely fashion as outlined under current State and federal law. Providers who accept payment from the program for services rendered may not bill any patient for covered services. Providers may elect either to participate fully, or not at all, in the program.

Section 133-45. Long-term care payment. The Board shall establish funding for long-term care services, including in-home, nursing home, and community-based care. A local public agency shall be established in each community to determine eligibility and coordinate home and nursing home long-term care. This agency may contract with long-term care providers for the full range of needed long-term care services.

Section 133-50. Mental health services. The program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions. The program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, including institutional care.

Section 133-55. Payment for prescription medications, medical supplies, and medically necessary assistive equipment.

(a) The program shall establish a single prescription drug formulary and list of approved durable medical goods and supplies. The Board shall, by itself or by a committee of health professionals and related individuals appointed by the Board and called the Pharmaceutical and Durable Medical Goods Committee, meet on a quarterly basis to discuss, reverse, add to, or remove items from the formulary according to sound medical practice.

(b) The Pharmaceutical and Durable Medical Goods Committee shall negotiate the prices of pharmaceuticals and durable medical goods with suppliers or manufacturers on an open bid competitive basis. Prices shall be reviewed, negotiated, or renegotiated on no less than an annual basis. The Pharmaceutical and Durable Medical Goods Committee shall establish a process of open forum to the public for the purposes of grievance and petition from suppliers, provider groups, and the public regarding the formulary no less than 2 times a year.

(c) All pharmacy and durable medical goods vendors must be licensed to distribute medical goods through the regulations outlined by the Board.

(d) All decisions and determinations of the Pharmaceutical and Durable Medical Goods Committee must be presented to and approved by the Board on an annual basis.

Section 133-60. Illinois Health Services Governing Board.

(a) The program shall be administered by an independent agency known as the Illinois Health Services Governing Board. The Board will consist of a Commissioner, a Chief Medical Officer, and public State board members. The Board is responsible for administration of the program, including:

(1) implementation of eligibility standards and program enrollment;

(2) adoption of the benefits package;

(3) establishing formulas for setting health expenditure budgets;

(4) administration of global budgets, capital expenditure budgets, and prompt reimbursement of providers;

(5) negotiations of service fee schedules and prices for prescription drugs and durable medical supplies;

(6) recommending evidence-based changes to benefits; and

(7) quality and planning functions, including criteria for capital expansion and infrastructure development, measurement and evaluation of health quality indicators, and the establishment of regions for long-term care integration.

(b) At least one-third of the members of the Board, including all committees dedicated to benefits design, health

planning, quality, and long-term care, shall be consumer representatives.

Section 133-65. Patients' rights. The program shall protect the rights and privacy of the patients that it serves in accordance with all current State and federal statutes. With the development of the electronic medical records, patients shall be afforded the right and option of keeping any portion of their medical records separate from the electronic medical records. Patients have the right to access their medical records upon demand.

Section 133-70. Compensation. The Commissioner, the Chief Medical Officer, public State board members, and employees of the program shall be compensated in accordance with the current pay scale for State employees and as deemed professionally appropriate by the General Assembly and reviewed in accordance with all other State employees.

## Title VII. Hospital Closure

### Article 135.

Section 135-5. The Illinois Health Facilities Planning Act is amended by changing Sections 4 and 8.7 and by adding Section 5.5 as follows:

(20 ILCS 3960/4) (from Ch. 111 1/2, par. 1154)

(Section scheduled to be repealed on December 31, 2029)

Sec. 4. Health Facilities and Services Review Board; membership; appointment; term; compensation; quorum.

(a) There is created the Health Facilities and Services Review Board, which shall perform the functions described in this Act. The Department shall provide operational support to the Board as necessary, including the provision of office space, supplies, and clerical, financial, and accounting services. The Board may contract for functions or operational support as needed. The Board may also contract with experts related to specific health services or facilities and create technical advisory panels to assist in the development of criteria, standards, and procedures used in the evaluation of applications for permit and exemption.

(b) The State Board shall consist of 11 ~~9~~ voting members. All members shall be residents of Illinois and at least 4 shall reside outside the Chicago Metropolitan Statistical Area. Consideration shall be given to potential appointees who reflect the ethnic and cultural diversity of the State. Neither Board members nor Board staff shall be convicted felons or have pled guilty to a felony.

Each member shall have a reasonable knowledge of the practice, procedures and principles of the health care delivery system in Illinois, including at least 5 members who shall be

knowledgeable about health care delivery systems, health systems planning, finance, or the management of health care facilities currently regulated under the Act. One member shall be a representative of a non-profit health care consumer advocacy organization. Two members shall be representatives from the community with experience on the effects of discontinuing health care services or the closure of health care facilities on the surrounding community. A spouse, parent, sibling, or child of a Board member cannot be an employee, agent, or under contract with services or facilities subject to the Act. Prior to appointment and in the course of service on the Board, members of the Board shall disclose the employment or other financial interest of any other relative of the member, if known, in service or facilities subject to the Act. Members of the Board shall declare any conflict of interest that may exist with respect to the status of those relatives and recuse themselves from voting on any issue for which a conflict of interest is declared. No person shall be appointed or continue to serve as a member of the State Board who is, or whose spouse, parent, sibling, or child is, a member of the Board of Directors of, has a financial interest in, or has a business relationship with a health care facility.

Notwithstanding any provision of this Section to the contrary, the term of office of each member of the State Board serving on the day before the effective date of this amendatory Act of the 96th General Assembly is abolished on the date upon

which members of the 9-member Board, as established by this amendatory Act of the 96th General Assembly, have been appointed and can begin to take action as a Board.

(c) The State Board shall be appointed by the Governor, with the advice and consent of the Senate. Not more than 5 of the appointments shall be of the same political party at the time of the appointment.

The Secretary of Human Services, the Director of Healthcare and Family Services, and the Director of Public Health, or their designated representatives, shall serve as ex-officio, non-voting members of the State Board.

(d) Of those 9 members initially appointed by the Governor following the effective date of this amendatory Act of the 96th General Assembly, 3 shall serve for terms expiring July 1, 2011, 3 shall serve for terms expiring July 1, 2012, and 3 shall serve for terms expiring July 1, 2013. Thereafter, each appointed member shall hold office for a term of 3 years, provided that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his or her predecessor was appointed shall be appointed for the remainder of such term and the term of office of each successor shall commence on July 1 of the year in which his predecessor's term expires. Each member shall hold office until his or her successor is appointed and qualified. The Governor may reappoint a member for additional terms, but no member shall serve more than 3 terms, subject to review and re-approval

every 3 years.

(e) State Board members, while serving on business of the State Board, shall receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. Until March 1, 2010, a member of the State Board who experiences a significant financial hardship due to the loss of income on days of attendance at meetings or while otherwise engaged in the business of the State Board may be paid a hardship allowance, as determined by and subject to the approval of the Governor's Travel Control Board.

(f) The Governor shall designate one of the members to serve as the Chairman of the Board, who shall be a person with expertise in health care delivery system planning, finance or management of health care facilities that are regulated under the Act. The Chairman shall annually review Board member performance and shall report the attendance record of each Board member to the General Assembly.

(g) The State Board, through the Chairman, shall prepare a separate and distinct budget approved by the General Assembly and shall hire and supervise its own professional staff responsible for carrying out the responsibilities of the Board.

(h) The State Board shall meet at least every 45 days, or as often as the Chairman of the State Board deems necessary, or upon the request of a majority of the members.

(i) Five members of the State Board shall constitute a quorum. The affirmative vote of 5 of the members of the State

Board shall be necessary for any action requiring a vote to be taken by the State Board. A vacancy in the membership of the State Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the State Board as provided by this Act.

(j) A State Board member shall disqualify himself or herself from the consideration of any application for a permit or exemption in which the State Board member or the State Board member's spouse, parent, sibling, or child: (i) has an economic interest in the matter; or (ii) is employed by, serves as a consultant for, or is a member of the governing board of the applicant or a party opposing the application.

(k) The Chairman, Board members, and Board staff must comply with the Illinois Governmental Ethics Act.

(Source: P.A. 99-527, eff. 1-1-17; 100-681, eff. 8-3-18.)

(20 ILCS 3960/5.5 new)

Sec. 5.5. Moratorium on hospital closures. Notwithstanding any law or rule to the contrary, due to the COVID-19 pandemic, the State shall institute a moratorium on the closure of hospitals until December 31, 2023. As such, no hospital shall close or reduce capacity below the hospital's capacity as of January 1, 2020 before the end of such moratorium.

(b) This Section is repealed on January 1, 2024.

(20 ILCS 3960/8.7)

(Section scheduled to be repealed on December 31, 2029)

Sec. 8.7. Application for permit for discontinuation of a health care facility or category of service; public notice and public hearing.

(a) Upon a finding that an application to close a health care facility or discontinue a category of service is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's website and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.

Upon the completion of an application to close a health care facility or discontinue a category of service, the State Board shall conduct a racial equity impact assessment to

determine the effect of the closure or discontinuation of service on racial and ethnic minorities. The results of the racial equity impact assessment shall be made available to the public.

An application to close a health care facility shall only be deemed complete if it includes evidence that the health care facility provided written notice at least 30 days prior to filing the application of its intent to do so to the municipality in which it is located, the State Representative and State Senator of the district in which the health care facility is located, the State Board, the Director of Public Health, and the Director of Healthcare and Family Services. The changes made to this subsection by this amendatory Act of the 101st General Assembly shall apply to all applications submitted after the effective date of this amendatory Act of the 101st General Assembly.

(b) No later than 30 days after issuance of a permit to close a health care facility or discontinue a category of service, the permit holder shall give written notice of the closure or discontinuation to the State Senator and State Representative serving the legislative district in which the health care facility is located.

(c) If there is a pending lawsuit that challenges an application to discontinue a health care facility that either names the Board as a party or alleges fraud in the filing of the application, the Board may defer action on the application

for up to 6 months after the date of the initial deferral of the application.

(d) The changes made to this Section by this amendatory Act of the 101st General Assembly shall apply to all applications submitted after the effective date of this amendatory Act of the 101st General Assembly.

(Source: P.A. 101-83, eff. 7-15-19; 101-650, eff. 7-7-20.)

## Title VIII. Managed Care Organization Reform

### Article 145.

Section 145-5. The Illinois Public Aid Code is amended by changing Section 5-30.1 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" include:

(1) emergency services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(2) emergency medical screening examinations, as defined by Section 10 of the Managed Care Reform and

Patient Rights Act;

(3) post-stabilization medical services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act; and

(4) emergency medical conditions, as defined by Section 10 of the Managed Care Reform and Patient Rights Act.

(b) As provided by Section 5-16.12, managed care organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act.

(c) An MCO shall pay any provider of emergency services that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates.

(d) An MCO shall pay for all post-stabilization services as a covered service in any of the following situations:

(1) the MCO authorized such services;

(2) such services were administered to maintain the enrollee's stabilized condition within one hour after a request to the MCO for authorization of further

post-stabilization services;

(3) the MCO did not respond to a request to authorize such services within one hour;

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

(2) The MCO shall cover emergency services provided to

enrollees who are temporarily away from their residence and outside the contracting area to the extent that the enrollees would be entitled to the emergency services if they still were within the contracting area.

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not covered services under the contract.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's screening and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

(6) The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the enrollee's care; or

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in place, taking into consideration health professional shortage areas and medically underserved areas;

(B) publicly release an explanation of its process for analyzing network adequacy;

(C) periodically ensure that an MCO continues to have an adequate network in place; and

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3.

(2) Each MCO shall confirm its receipt of information submitted specific to physician or dentist additions or physician or dentist deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians or dentists, and electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a claim within 30 days of receiving a claim that contains all the essential information needed to adjudicate the claim.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(3) The MCO shall pay a penalty that is at least equal to the timely payment interest penalty imposed under Section 368a of the Illinois Insurance Code for any claims not timely paid.

(A) When an MCO is required to pay a timely payment interest penalty to a provider, the MCO must calculate and pay the timely payment interest penalty that is due to the provider within 30 days after the payment of the claim. In no event shall a provider be required to request or apply for payment of any owed timely payment interest penalties.

(B) Such payments shall be reported separately from the claim payment for services rendered to the MCO's enrollee and clearly identified as interest payments.

(4)(A) The Department shall require MCOs to expedite payments to providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), on a schedule at least as frequently as the providers are paid under the Department's

fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, and the PIP program ensures that any expedited provider receives regular and periodic payments based on prior period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate in the assignment of coverage responsibility between MCOs or the fee-for-service system, except for instances when an individual is deemed to have not been eligible for coverage

under the Illinois Medicaid program; and

(2) the Department shall, by December 31, 2016, adopt rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with

industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for

health care services rendered by the provider to an enrollee of the MCO with which the provider disagrees. Disputes shall not be submitted to the portal until the provider has availed itself of the MCO's internal dispute resolution process. Disputes that are submitted to the MCO internal dispute resolution process may be submitted to the Department of Healthcare and Family Services' complaint portal no sooner than 30 days after submitting to the MCO's internal process and not later than 30 days after the unsatisfactory resolution of the internal MCO process or 60 days after submitting the dispute to the MCO internal process. Multiple claim disputes involving the same MCO may be submitted in one complaint, regardless of whether the claims are for different enrollees, when the specific reason for non-payment of the claims involves a common question of fact or policy. Within 10 business days of receipt of a complaint, the Department shall present such disputes to the appropriate MCO, which shall then have 30 days to issue its written proposal to resolve the dispute. The Department may grant one 30-day extension of this time frame to one of the parties to resolve the dispute. If the dispute remains unresolved at the end of this time frame or the provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall

present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its website a report on the calculation of each managed care organization's medical loss ratio showing the following:

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

(vi) Expenses for activities that improve health care quality as allowed by the Department.

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout period determined by the Department.

(g-10)(1) "Liability effective date" means the date on which an MCO becomes responsible for payment for medically necessary and covered services rendered by a provider to one of its enrollees in accordance with the contract terms between the MCO and the provider. The liability effective date shall be the later of:

(A) The execution date of a network participation contract agreement.

(B) The date the provider or its representative submits to the MCO the complete and accurate standardized roster form for the provider in the format approved by the Department.

(C) The provider effective date contained within the Department's provider enrollment subsystem within the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) System.

(2) The standardized roster form may be submitted to the MCO at the same time that the provider submits an enrollment application to the Department through IMPACT.

(3) By October 1, 2019, the Department shall require all

MCOs to update their provider directory with information for new practitioners of existing contracted providers within 30 days of receipt of a complete and accurate standardized roster template in the format approved by the Department provided that the provider is effective in the Department's provider enrollment subsystem within the IMPACT system. Such provider directory shall be readily accessible for purposes of selecting an approved health care provider and comply with all other federal and State requirements.

(g-11) The Department shall work with relevant stakeholders on the development of operational guidelines to enhance and improve operational performance of Illinois' Medicaid managed care program, including, but not limited to, improving provider billing practices, reducing claim rejections and inappropriate payment denials, and standardizing processes, procedures, definitions, and response timelines, with the goal of reducing provider and MCO administrative burdens and conflict. The Department shall include a report on the progress of these program improvements and other topics in its Fiscal Year 2020 annual report to the General Assembly.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the

Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(h-5) MCOs shall be required to publish, at least quarterly for the preceding quarter, on their websites:

(1) the total number of claims received by the MCO;

(2) the number and monetary amount of claims payments made to a service provider as defined in Section 2-16 of this Code;

(3) the dates of services rendered for the claims payments made under paragraph (2);

(4) the dates the claims were received by the MCO for the claims payments made under paragraph (2); and

(5) the dates on which claims payments under paragraph (2) were released.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form

that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(Source: P.A. 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff. 6-4-18; 101-209, eff. 8-5-19.)

Article 150.

Section 150-5. The Illinois Public Aid Code is amended by changing Section 5-30.1 and by adding Section 5-30.15 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" include:

(1) emergency services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(2) emergency medical screening examinations, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(3) post-stabilization medical services, as defined by Section 10 of the Managed Care Reform and Patient Rights

Act; and

(4) emergency medical conditions, as defined by Section 10 of the Managed Care Reform and Patient Rights Act.

(b) As provided by Section 5-16.12, managed care organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act.

(c) An MCO shall pay any provider of emergency services that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates.

(d) An MCO shall pay for all post-stabilization services as a covered service in any of the following situations:

(1) the MCO authorized such services;

(2) such services were administered to maintain the enrollee's stabilized condition within one hour after a request to the MCO for authorization of further post-stabilization services;

(3) the MCO did not respond to a request to authorize such services within one hour;

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

(2) The MCO shall cover emergency services provided to enrollees who are temporarily away from their residence and outside the contracting area to the extent that the enrollees would be entitled to the emergency services if

they still were within the contracting area.

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not covered services under the contract.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's screening and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

(6) The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the enrollee's care; or

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in place, taking into consideration health professional shortage areas and medically underserved areas;

(B) publicly release an explanation of its process for analyzing network adequacy;

(C) periodically ensure that an MCO continues to have an adequate network in place; ~~and~~

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3; and ~~.~~

(E) require MCOs to: (i) ensure that any provider under contract with an MCO on the date of service is paid for any medically necessary service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available roster of available providers; and (ii) ensure that all contracted providers are listed on an updated roster within 7 days of entering into a contract with the MCO and that such roster is readily accessible to all medical assistance enrollees for purposes of selecting an approved healthcare provider.

(2) Each MCO shall confirm its receipt of information submitted specific to physician or dentist additions or

physician or dentist deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians or dentists, and electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a claim within 30 days of receiving a claim that contains all the essential information needed to adjudicate the claim.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(3) The MCO shall pay a penalty that is at least equal to the timely payment interest penalty imposed under Section 368a of the Illinois Insurance Code for any claims not timely paid.

(A) When an MCO is required to pay a timely payment interest penalty to a provider, the MCO must calculate and pay the timely payment interest penalty that is due to the provider within 30 days after the payment of the claim. In no event shall a provider be required to request or apply for payment of any owed timely payment interest penalties.

(B) Such payments shall be reported separately

from the claim payment for services rendered to the MCO's enrollee and clearly identified as interest payments.

(4) ~~(A)~~ The Department shall require MCOs to expedite payments to providers based on criteria that include, but are not limited to:

(A) At a minimum, each MCO shall ensure that providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), are paid by the MCO on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, if ~~and~~ the PIP program ensures that any expedited provider receives regular and periodic payments based on prior period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate in the assignment of coverage responsibility between MCOs or the fee-for-service system, except for instances when an individual is deemed to have not been eligible for coverage under the Illinois Medicaid program; and

(2) the Department shall, by December 31, 2016, adopt rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry

representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of

metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and

denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for health care services rendered by the provider to an enrollee of the MCO with which the provider disagrees. Disputes shall not be submitted to the portal until the provider has availed itself of the MCO's internal dispute resolution process. Disputes that are submitted to the MCO internal dispute resolution process may be submitted to the Department of Healthcare and Family Services' complaint portal no sooner than 30 days after submitting to the MCO's internal process and not later than 30 days after the unsatisfactory resolution of the internal MCO process or 60 days after submitting the dispute to the MCO internal process. Multiple claim disputes involving the same MCO may be submitted in one complaint, regardless of whether the claims are for different enrollees, when the specific reason for non-payment of the claims involves a common

question of fact or policy. Within 10 business days of receipt of a complaint, the Department shall present such disputes to the appropriate MCO, which shall then have 30 days to issue its written proposal to resolve the dispute. The Department may grant one 30-day extension of this time frame to one of the parties to resolve the dispute. If the dispute remains unresolved at the end of this time frame or the provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the

Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its website a report on the calculation of each managed care organization's medical loss ratio showing the following:

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

(vi) Expenses for activities that improve health care quality as allowed by the Department.

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout period determined by the Department.

(g-10)(1) "Liability effective date" means the date on which an MCO becomes responsible for payment for medically necessary and covered services rendered by a provider to one of its enrollees in accordance with the contract terms between the MCO and the provider. The liability effective date shall be the later of:

(A) The execution date of a network participation contract agreement.

(B) The date the provider or its representative submits to the MCO the complete and accurate standardized roster form for the provider in the format approved by the Department.

(C) The provider effective date contained within the Department's provider enrollment subsystem within the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) System.

(2) The standardized roster form may be submitted to the MCO at the same time that the provider submits an enrollment application to the Department through IMPACT.

(3) By October 1, 2019, the Department shall require all MCOs to update their provider directory with information for new practitioners of existing contracted providers within 30 days of receipt of a complete and accurate standardized roster template in the format approved by the Department provided that the provider is effective in the Department's provider enrollment subsystem within the IMPACT system. Such provider directory shall be readily accessible for purposes of selecting an approved health care provider and comply with all other federal and State requirements.

(g-11) The Department shall work with relevant stakeholders on the development of operational guidelines to enhance and improve operational performance of Illinois' Medicaid managed care program, including, but not limited to, improving provider billing practices, reducing claim

rejections and inappropriate payment denials, and standardizing processes, procedures, definitions, and response timelines, with the goal of reducing provider and MCO administrative burdens and conflict. The Department shall include a report on the progress of these program improvements and other topics in its Fiscal Year 2020 annual report to the General Assembly.

(g-12) Notwithstanding any other provision of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely claims submission requirements under this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the

individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(h-5) MCOs shall be required to publish, at least quarterly for the preceding quarter, on their websites:

(1) the total number of claims received by the MCO;

(2) the number and monetary amount of claims payments made to a service provider as defined in Section 2-16 of this Code;

(3) the dates of services rendered for the claims payments made under paragraph (2);

(4) the dates the claims were received by the MCO for the claims payments made under paragraph (2); and

(5) the dates on which claims payments under paragraph (2) were released.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health

information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(k) The requirements of this Section added by this amendatory Act of the 101st General Assembly shall apply to services provided on or after the first day of the month that begins 60 days after the effective date of this amendatory Act of the 101st General Assembly.

(Source: P.A. 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff. 6-4-18; 101-209, eff. 8-5-19.)

(305 ILCS 5/5-30.15 new)

Sec. 5-30.15. Discharge notification and facility placement of individuals; managed care. Whenever a hospital provides notice to a managed care organization (MCO) that an individual covered under the State's medical assistance program has received a discharge order from the attending physician and is ready for discharge from an inpatient hospital stay to another level of care, the MCO shall secure the individual's placement in or transfer to another facility within 24 hours of receiving the hospital's notification, or shall pay the hospital a daily rate equal to the hospital's daily rate associated with the stay ending, including all applicable add-on adjustment payments.

Article 155.

Section 155-5. The Illinois Public Aid Code is amended by adding Section 5-30.17 as follows:

(305 ILCS 5/5-30.17 new)

Sec. 5-30.17. Medicaid Managed Care Oversight Commission.

(a) The Medicaid Managed Care Oversight Commission is created within the Department of Healthcare and Family Services to evaluate the effectiveness of Illinois' managed care program.

(b) The Commission shall consist of the following members:

(1) One member of the Senate, appointed by the Senate President, who shall serve as co-chair.

(2) One member of the House of Representatives, appointed by the Speaker of the House of Representatives, who shall serve as co-chair.

(3) One member of the House of Representatives, appointed by the Minority Leader of the House of Representatives.

(4) One member of the Senate, appointed by the Senate Minority Leader.

(5) One member representing the Department of Healthcare and Family Services, appointed by the Governor.

(6) One member representing the Department of Public

Health, appointed by the Governor.

(7) One member representing the Department of Human Services, appointed by the Governor.

(8) One member representing the Department of Children and Family Services, appointed by the Governor.

(9) One member of a statewide association representing Medicaid managed care plans.

(10) One member of a statewide association representing hospitals.

(11) Two academic experts on Medicaid managed care programs.

(12) One member of a statewide association representing primary care providers.

(13) One member of a statewide association representing behavioral health providers.

(c) The Director of Healthcare and Family Services and chief of staff, or their designees, shall serve as the Commission's executive administrators in providing administrative support, research support, and other administrative tasks requested by the Commission's co-chairs. Any expenses, including, but not limited to, travel and housing, shall be paid for by the Department's existing budget.

(d) The members of the Commission shall receive no compensation for their services as members of the Commission.

(e) The Commission shall meet quarterly beginning as soon as is practicable after the effective date of this amendatory

Act of the 101st General Assembly.

(f) The Commission shall:

(1) review data on health outcomes of Medicaid managed care members;

(2) review current care coordination and case management efforts and make recommendations on expanding care coordination to additional populations with a focus on the social determinants of health;

(3) review and assess the appropriateness of metrics used in the Pay-for-Performance programs;

(4) review the Department's prior authorization and utilization management requirements and recommend adaptations for the Medicaid population;

(5) review managed care performance in meeting diversity contracting goals and the use of funds dedicated to meeting such goals, including, but not limited to, contracting requirements set forth in the Business Enterprise for Minorities, Women, and Persons with Disabilities Act; recommend strategies to increase compliance with diversity contracting goals in collaboration with the Chief Procurement Officer for General Services and the Business Enterprise Council for Minorities, Women, and Persons with Disabilities; and recoup any misappropriated funds for diversity contracting;

(6) review data on the effectiveness of claims

processing to medical providers;

(7) review the adequacy of the Medicaid managed care network and member access to health care services, including specialty care services;

(8) review value-based and other alternative payment methodologies to enhance program efficiency and improve health outcomes;

(9) review the compliance of all managed care entities in State contracts and recommend reasonable financial penalties for any noncompliance; and

(10) produce an annual report detailing the Commission's findings based upon its review of research conducted under this Section, including specific recommendations, if any, and any other information the Commission may deem proper in furtherance of its duties under this Section.

(g) The Department of Healthcare and Family Services shall impose financial penalties on any managed care entity that is found to not be in compliance with any provision of a State contract. In addition to any financial penalties imposed under this subsection, the Department shall recoup any misappropriated funds identified by the Commission for the purpose of meeting the Business Enterprise Program requirements set forth in contracts with managed care entities. Any financial penalty imposed or funds recouped in accordance with this Section shall be deposited into the Managed Care

Oversight Fund.

When recommending reasonable financial penalties upon a finding of noncompliance under this subsection, the Commission shall consider the scope and nature of the noncompliance and whether or not it was intentional or unreasonable. In imposing a financial penalty on any managed care entity that is found to not be in compliance, the Department of Healthcare and Family Services shall consider the recommendations of the Commission.

Upon conclusion by the Department of Healthcare and Family Services that any managed care entity is not in compliance with its contract with the State based on the findings of the Commission, it shall issue the managed care entity a written notification of noncompliance. The written notice shall specify any financial penalty to be imposed and whether this penalty is consistent with the recommendation of the Commission. If the specified financial penalty differs from the Commission's recommendation, the Department of Healthcare and Family Services shall specify why the Department did not impose the recommended penalty and how the Department arrived at its determination of the reasonableness of the financial penalty imposed.

Within 14 calendar days after receipt of the notification of noncompliance, the managed care entity shall submit a written response to the Department of Healthcare and Family Services. The response shall indicate whether the managed care entity: (i) disputes the determination of noncompliance,

including any facts or conduct to show compliance; (ii) agrees to the determination of noncompliance and any financial penalty imposed; or (iii) agrees to the determination of noncompliance but disputes the financial penalty imposed.

Failure to respond to the notification of noncompliance shall be deemed acceptance of the Department of Healthcare and Family Services' determination of noncompliance.

If a managed care entity disputes any part of the Department of Healthcare and Family Services' determination of noncompliance, within 30 calendar days of receipt of the managed care entity's response the Department shall respond in writing whether it (i) agrees to review its determination of noncompliance or (ii) disagrees with the entity's disputation.

The Department of Healthcare and Family Services shall issue a written notice to the Commission of the dispute and its chosen response at the same time notice is made to the managed care entity.

Nothing in this Section limits or alters a person or entity's existing rights or protections under State or federal law.

(h) A decision of the Department of Healthcare and Family Services to impose a financial penalty on a managed care entity for noncompliance under subsection (g) is subject to judicial review under the Administrative Review Law.

(i) The Department shall issue quarterly reports to the Governor and the General Assembly indicating: (i) the number of

determinations of noncompliance since the last quarter; (ii) the number of financial penalties imposed; and (iii) the outcome or status of each determination.

(j) Beginning January 1, 2022, and for each year thereafter, the Commission shall submit a report of its findings and recommendations to the General Assembly. The report to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct.

Article 160.

Section 160-5. The State Finance Act is amended by adding Sections 5.935 and 6z-124 as follows:

(30 ILCS 105/5.935 new)

Sec. 5.935. The Managed Care Oversight Fund.

(30 ILCS 105/6z-124 new)

Sec. 6z-124. Managed Care Oversight Fund. The Managed Care Oversight Fund is created as a special fund in the State treasury. Subject to appropriation, available annual moneys in the Fund shall be used by the Department of Healthcare and Family Services to support emergency procurement and sole source contracting with women and minority-owned businesses as

part of the Department's Business Enterprise Program requirements. The Department shall prioritize contracts for care coordination services in allocating funds. Funds may not be used for institutional overhead costs, indirect costs, or other organizational levies.

Article 165.

Section 165-5. The Illinois Public Aid Code is amended by adding Section 5-45 as follows:

(305 ILCS 5/5-45 new)

Sec. 5-45. Termination of managed care. The Department of Healthcare and Family Services shall not renew, re-enter, renegotiate, change orders, or amend any contract or agreement it entered with a managed care organization, as defined in Section 5-30.1, that was solicited under the State of Illinois Medicaid Managed Care Organization Request for Proposals (2018-24-001). Any care health plan administered by a managed care organization that entered a contract with the Department under the State of Illinois Medicaid Managed Care Organization Request for Proposals 2018-24-001) shall be transitioned to the State's fee-for-service medical assistance program upon the expiration of the managed care organization's contract with the Department until such time the Department enters a new contract in accordance with Section 5-30.6. Any new contract entered

into by the Department with a Managed Care Organization in accordance with Section 5-30.6 shall specify the patient diseases that require care planning and assessment, including, but not limited to, social determinants of health as determined by the Centers for Disease Control and Prevention.

Article 170.

Section 170-5. The Illinois Public Aid Code is amended by adding Section 5-30.16 as follows:

(305 ILCS 5/5-30.16 new)

Sec. 5-30.16. Managed care organizations; subcontracting diversity requirements.

(a) In this Section, "managed care organization" has the meaning given to that term in Section 5-30.1.

(b) The Illinois Department shall require each managed care organization participating in the medical assistance program established under this Article to satisfy any minority-owned or women-owned business subcontracting requirements to which the managed care organization is subject under the contract.

(c) The Illinois Department shall terminate its contract with any managed care organization that does not meet the minority-owned or women-owned business subcontracting requirements under its contract with the State. The Illinois Department shall terminate the contract no later than 60 days

after receiving a contractually required report indicating that the managed care organization has not met the subcontracting goals. To ensure there is no disruption of care to Medicaid recipients who are enrolled with a managed care organization whose contract is terminated as provided under this subsection, the Illinois Department shall reassign to another managed care plan any Medicaid recipient who will lose healthcare coverage as a result of the Illinois Department's decision to terminate its contract with the managed care organization.

Title IX. Maternal and Infant Mortality

Article 175.

Section 175-5. The Illinois Public Aid Code is amended by adding Section 5-18.5 as follows:

(305 ILCS 5/5-18.5 new)

Sec. 5-18.5. Perinatal doula and evidence-based home visiting services.

(a) As used in this Section:

"Home visiting" means a voluntary, evidence-based strategy used to support pregnant people, infants, and young children and their caregivers to promote infant, child, and maternal health, to foster educational development and school

readiness, and to help prevent child abuse and neglect. Home visitors are trained professionals whose visits and activities focus on promoting strong parent-child attachment to foster healthy child development.

"Perinatal doula" means a trained provider who provides regular, voluntary physical, emotional, and educational support, but not medical or midwife care, to pregnant and birthing persons before, during, and after childbirth, otherwise known as the perinatal period.

"Perinatal doula training" means any doula training that focuses on providing support throughout the prenatal, labor and delivery, or postpartum period, and reflects the type of doula care that the doula seeks to provide.

(b) Notwithstanding any other provision of this Article, perinatal doula services and evidence-based home visiting services shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. Perinatal doula services include regular visits beginning in the prenatal period and continuing into the postnatal period, inclusive of continuous support during labor and delivery, that support healthy pregnancies and positive birth outcomes. Perinatal doula services may be embedded in an existing program, such as evidence-based home visiting. Perinatal doula services provided during the prenatal period may be provided weekly, services provided during the labor and delivery period may be provided for the entire duration of

labor and the time immediately following birth, and services provided during the postpartum period may be provided up to 12 months postpartum.

(c) The Department of Healthcare and Family Services shall adopt rules to administer this Section. In this rulemaking, the Department shall consider the expertise of and consult with doula program experts, doula training providers, practicing doulas, and home visiting experts, along with State agencies implementing perinatal doula services and relevant bodies under the Illinois Early Learning Council. This body of experts shall inform the Department on the credentials necessary for perinatal doula and home visiting services to be eligible for Medicaid reimbursement and the rate of reimbursement for home visiting and perinatal doula services in the prenatal, labor and delivery, and postpartum periods. Every 2 years, the Department shall assess the rates of reimbursement for perinatal doula and home visiting services and adjust rates accordingly.

{d) The Department shall seek such State plan amendments or waivers as may be necessary to implement this Section and shall secure federal financial participation for expenditures made by the Department in accordance with this Section.

Title X. Miscellaneous

Article 999.

Section 999-99. Effective date. This Act takes effect upon becoming law, except that Article 133 takes effect January 1, 2023.".