Rep. Camille Y. Lilly

Filed: 3/10/2021

AMENDMENT TO HOUSE BILL 158

AMENDMENT NO. _____. Amend House Bill 158 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 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, the Department of Healthcare and Family Services, and the Department of Human 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.

(e) To ensure high-quality service, the Illinois Community Health Worker Certification Board shall examine and consider for adoption best practices from other states that have implemented policies to allow for alternative opportunities to demonstrate competency in core skills and knowledge in addition to certification.

(f) The Department of Public Health shall explore ways to compensate members of the Board.

Section 5-20. Reimbursement. Community health worker services shall be covered under the medical assistance program, subject to appropriation, 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 diagnosis-related patient services, for which community health workers will be eligible for reimbursement and shall request approval from the federal Centers for Medicare and Medicaid Services to reimburse community health worker services under the medical assistance program. For reimbursement under the medical assistance program, a community health worker must work under the supervision of an enrolled medical program provider, as specified by the Department, and certification shall be required for reimbursement. The supervision of enrolled medical program providers and certification are not required for community health workers who receive reimbursement through managed care administrative moneys. Noncertified community health workers are reimbursable at the discretion of managed care entities following availability of community health worker certification. 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.

Section 5-23. Certification. Certification shall not be required for employment of community health workers. Noncertified community health workers may be employed through funding sources outside of the medical assistance program.

Section 5-25. Rules. The Department of Public Health and the Department of Healthcare and Family Services may adopt rules for the implementation and administration of this Act.

Title III. Hospital Reform

Article 10.

Section 10-5. The Hospital Licensing Act is amended by changing Section 10.4 as follows:

(210 ILCS 85/10.4) (from Ch. 111 1/2, par. 151.4)

Sec. 10.4. Medical staff privileges.

(a) Any hospital licensed under this Act or any hospital organized under the University of Illinois Hospital Act shall, prior to the granting of any medical staff privileges to an applicant, or renewing a current medical staff member's privileges, request of the Director of Professional Regulation information concerning the licensure status<u>, proper credentials, required certificates,</u> and any disciplinary

action taken against the applicant's or medical staff member's license, except: (1) for medical personnel who enter a hospital to obtain organs and tissues for transplant from a donor in accordance with the Illinois Anatomical Gift Act; or (2) for medical personnel who have been granted disaster privileges pursuant to the procedures and requirements established by rules adopted by the Department. Any hospital and any employees of the hospital or others involved in granting privileges who, in good faith, grant disaster privileges pursuant to this Section to respond to an emergency shall not, as a result of their acts or omissions, be liable for civil damages for granting or denying disaster privileges except in the event of willful and wanton misconduct, as that term is defined in Section 10.2 of this Act. Individuals granted privileges who provide care in an emergency situation, in good faith and without direct compensation, shall not, as a result of their acts or omissions, except for acts or omissions involving willful and wanton misconduct, as that term is defined in Section 10.2 of this Act, on the part of the person, be liable for civil damages. The Director of Professional Regulation shall transmit, in writing and in a timely fashion, such information regarding the license of the applicant or the medical staff member, including the record of imposition of any periods of supervision or monitoring as a result of alcohol or substance abuse, as provided by Section 23 of the Medical Practice Act of 1987, and such information as

may have been submitted to the Department indicating that the application or medical staff member has been denied, or has surrendered, medical staff privileges at a hospital licensed under this Act, or any equivalent facility in another state or territory of the United States. The Director of Professional Regulation shall define by rule the period for timely response to such requests.

No transmittal of information by the Director of Professional Regulation, under this Section shall be to other than the president, chief operating officer, chief administrative officer, or chief of the medical staff of a hospital licensed under this Act, a hospital organized under the University of Illinois Hospital Act, or a hospital operated by the United States, or any of its instrumentalities. The information so transmitted shall be afforded the same status as is information concerning medical studies by Part 21 of Article VIII of the Code of Civil Procedure, as now or hereafter amended.

(b) All hospitals licensed under this Act, except county hospitals as defined in subsection (c) of Section 15-1 of the Illinois Public Aid Code, shall comply with, and the medical staff bylaws of these hospitals shall include rules consistent with, the provisions of this Section in granting, limiting, renewing, or denying medical staff membership and clinical staff privileges. Hospitals that require medical staff members to possess faculty status with a specific institution of

higher education are not required to comply with subsection (1) below when the physician does not possess faculty status.

(1) Minimum procedures for pre-applicants and applicants for medical staff membership shall include the following:

(A) Written procedures relating to the acceptance and processing of pre-applicants or applicants for medical staff membership, which should be contained in medical staff bylaws.

(B) Written procedures to be followed in determining a pre-applicant's or an applicant's qualifications for being granted medical staff membership and privileges.

(C) Written criteria to be followed in evaluating a pre-applicant's or an applicant's qualifications.

(D) An evaluation of a pre-applicant's or an applicant's current health status and current license status in Illinois.

(E) A written response to each pre-applicant or applicant that explains the reason or reasons for any adverse decision (including all reasons based in whole or in part on the applicant's medical qualifications or any other basis, including economic factors).

(2) Minimum procedures with respect to medical staff and clinical privilege determinations concerning current members of the medical staff shall include the following:

(A) A written notice of an adverse decision.

(B) An explanation of the reasons for an adverse decision including all reasons based on the quality of medical care or any other basis, including economic factors.

(C) A statement of the medical staff member's right to request a fair hearing on the adverse decision before a hearing panel whose membership is mutually agreed upon by the medical staff and the hospital governing board. The hearing panel shall have independent authority to recommend action to the hospital governing board. Upon the request of the medical staff member or the hospital governing board, the hearing panel shall make findings concerning the nature of each basis for any adverse decision recommended to and accepted by the hospital governing board.

(i) Nothing in this subparagraph (C) limits a hospital's or medical staff's right to summarily suspend, without a prior hearing, a person's medical staff membership or clinical privileges if the continuation of practice of a medical staff member constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff. In the event that a hospital or the medical staff imposes a summary suspension,

the Medical Executive Committee, or other comparable governance committee of the medical staff as specified in the bylaws, must meet as soon as is reasonably possible to review the suspension and to recommend whether it should be affirmed, lifted, expunged, or modified if the suspended physician requests such review. A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists. This documentation or information must be available at the time the summary suspension decision is made and when the decision is reviewed by the Medical Executive Committee. If the Medical Executive Committee recommends that the summary suspension should be lifted, expunged, or modified, this recommendation must be reviewed and considered by the hospital governing board, or a committee of the board, on an expedited basis. Nothing in this subparagraph (C) shall affect the requirement that any requested hearing must be commenced within 15 days after the summary suspension and completed without delay unless otherwise agreed to by the parties. A fair hearing shall be commenced within 15 days after the suspension and completed without delay, except that when the medical staff member's

license to practice has been suspended or revoked by the State's licensing authority, no hearing shall be necessary.

(ii) Nothing in this subparagraph (C) limits a medical staff's right to permit, in the medical staff bylaws, summary suspension of membership or clinical privileges in designated administrative circumstances as specifically approved by the medical staff. This bylaw provision must specifically describe both the administrative circumstance that can result in a summary suspension and the length of the summary suspension. The opportunity for a fair hearing is required for any administrative summary suspension. Any requested hearing must be commenced within 15 days after the summary suspension and completed without delay. Adverse decisions other than suspension or other restrictions on the treatment or admission of patients may be imposed summarily and without a hearing under designated administrative circumstances as specifically provided for in the medical staff bylaws as approved by the medical staff.

(iii) If a hospital exercises its option to enter into an exclusive contract and that contract

results in the total or partial termination or reduction of medical staff membership or clinical privileges of a current medical staff member, the hospital shall provide the affected medical staff member 60 days prior notice of the effect on his or her medical staff membership or privileges. An affected medical staff member desiring a hearing under subparagraph (C) of this paragraph (2) must request the hearing within 14 days after the date he or she is so notified. The requested hearing shall be commenced and completed (with a report and recommendation to the affected medical staff member, hospital governing board, and medical staff) within 30 days after the date of the medical staff member's request. If agreed upon by both the medical staff and the hospital governing board, the medical staff bylaws may provide for longer time periods.

(C-5) All peer review used for the purpose of credentialing, privileging, disciplinary action, or other recommendations affecting medical staff membership or exercise of clinical privileges, whether relying in whole or in part on internal or external reviews, shall be conducted in accordance with the medical staff bylaws and applicable rules, regulations, or policies of the medical staff. If

external review is obtained, any adverse report utilized shall be in writing and shall be made part of the internal peer review process under the bylaws. The report shall also be shared with a medical staff peer review committee and the individual under review. If the medical staff peer review committee or the individual under review prepares a written response to the report of the external peer review within 30 days after receiving such report, the governing board shall consider the response prior to the implementation of any final actions by the governing board which may affect the individual's medical staff membership or clinical privileges. Any peer review that involves willful or wanton misconduct shall be subject to civil damages as provided for under Section 10.2 of this Act.

(D) A statement of the member's right to inspect all pertinent information in the hospital's possession with respect to the decision.

(E) A statement of the member's right to present witnesses and other evidence at the hearing on the decision.

(E-5) The right to be represented by a personal attorney.

(F) A written notice and written explanation of the decision resulting from the hearing.

(F-5) A written notice of a final adverse decision by a hospital governing board.

(G) Notice given 15 days before implementation of an adverse medical staff membership or clinical privileges decision based substantially on economic factors. This notice shall be given after the medical staff member exhausts all applicable procedures under this Section, including item (iii) of subparagraph (C) of this paragraph (2), and under the medical staff bylaws in order to allow sufficient time for the orderly provision of patient care.

(H) Nothing in this paragraph (2) of this subsection (b) limits a medical staff member's right to waive, in writing, the rights provided in subparagraphs (A) through (G) of this paragraph (2) of this subsection (b) upon being granted the written exclusive right to provide particular services at a hospital, either individually or as a member of a group. If an exclusive contract is signed by a representative of a group of physicians, a waiver contained in the contract shall apply to all members of the group unless stated otherwise in the contract.

(3) Every adverse medical staff membership and clinical privilege decision based substantially on economic factors shall be reported to the Hospital Licensing Board before the decision takes effect. These

reports shall not be disclosed in any form that reveals the identity of any hospital or physician. These reports shall be utilized to study the effects that hospital medical staff membership and clinical privilege decisions based upon economic factors have on access to care and the availability of physician services. The Hospital Licensing Board shall submit an initial study to the Governor and the General Assembly by January 1, 1996, and subsequent reports shall be submitted periodically thereafter.

(4) As used in this Section:

"Adverse decision" means a decision reducing, restricting, suspending, revoking, denying, or not renewing medical staff membership or clinical privileges.

"Economic factor" means any information or reasons for decisions unrelated to quality of care or professional competency.

"Pre-applicant" means a physician licensed to practice medicine in all its branches who requests an application for medical staff membership or privileges.

"Privilege" means permission to provide medical or other patient care services and permission to use hospital resources, including equipment, facilities and personnel that are necessary to effectively provide medical or other patient care services. This definition shall not be construed to require a hospital to acquire additional equipment, facilities, or personnel to accommodate the

granting of privileges.

(5) Any amendment to medical staff bylaws required because of this amendatory Act of the 91st General Assembly shall be adopted on or before July 1, 2001.

(c) All hospitals shall consult with the medical staff prior to closing membership in the entire or any portion of the medical staff or a department. If the hospital closes membership in the medical staff, any portion of the medical staff, or the department over the objections of the medical staff, then the hospital shall provide a detailed written explanation for the decision to the medical staff 10 days prior to the effective date of any closure. No applications need to be provided when membership in the medical staff or any relevant portion of the medical staff is closed.

(Source: P.A. 96-445, eff. 8-14-09; 97-1006, eff. 8-17-12.)

Article 15.

Section 15-3. The Illinois Health Finance Reform Act is amended by changing Section 4-4 as follows:

(20 ILCS 2215/4-4) (from Ch. 111 1/2, par. 6504-4)

Sec. 4-4. (a) Hospitals shall make available to prospective patients information on the normal charge incurred for any procedure or operation the prospective patient is considering.

(b) The Department of Public Health shall require hospitals to post, either by physical or electronic means, in prominent letters, ~~in letters no more than one inch in height~~ the established charges for services, where applicable, including but not limited to the hospital's private room charge, semi-private room charge, charge for a room with 3 or more beds, intensive care room charges, emergency room charge, operating room charge, electrocardiogram charge, anesthesia charge, chest x-ray charge, blood sugar charge, blood chemistry charge, tissue exam charge, blood typing charge and Rh factor charge. The definitions of each charge to be posted shall be determined by the Department.

(Source: P.A. 92-597, eff. 7-1-02.)

Section 15-5. The Hospital Licensing Act is amended by changing Sections 6, 6.14c, 10.10, and 11.5 as follows:

(210 ILCS 85/6) (from Ch. 111 1/2, par. 147)

Sec. 6. (a) Upon receipt of an application for a permit to establish a hospital the Director shall issue a permit if he finds (1) that the applicant is fit, willing, and able to provide a proper standard of hospital service for the community with particular regard to the qualification, background, and character of the applicant, (2) that the financial resources available to the applicant demonstrate an ability to construct, maintain, and operate a hospital in

accordance with the standards, rules, and regulations adopted pursuant to this Act, and (3) that safeguards are provided which assure hospital operation and maintenance consistent with the public interest having particular regard to safe, adequate, and efficient hospital facilities and services.

The Director may request the cooperation of county and multiple-county health departments, municipal boards of health, and other governmental and non-governmental agencies in obtaining information and in conducting investigations relating to such applications.

A permit to establish a hospital shall be valid only for the premises and person named in the application for such permit and shall not be transferable or assignable.

In the event the Director issues a permit to establish a hospital the applicant shall thereafter submit plans and specifications to the Department in accordance with Section 8 of this Act.

(b) Upon receipt of an application for license to open, conduct, operate, and maintain a hospital, the Director shall issue a license if he finds the applicant and the hospital facilities comply with standards, rules, and regulations promulgated under this Act. A license, unless sooner suspended or revoked, shall be renewable annually upon approval by the Department and payment of a license fee as established pursuant to Section 5 of this Act. Each license shall be issued only for the premises and persons named in the application and

shall not be transferable or assignable. Licenses shall be posted, either by physical or electronic means, in a conspicuous place on the licensed premises. The Department may, either before or after the issuance of a license, request the cooperation of the State Fire Marshal, county and multiple county health departments, or municipal boards of health to make investigations to determine if the applicant or licensee is complying with the minimum standards prescribed by the Department. The report and recommendations of any such agency shall be in writing and shall state with particularity its findings with respect to compliance or noncompliance with such minimum standards, rules, and regulations.

The Director may issue a provisional license to any hospital which does not substantially comply with the provisions of this Act and the standards, rules, and regulations promulgated by virtue thereof provided that he finds that such hospital has undertaken changes and corrections which upon completion will render the hospital in substantial compliance with the provisions of this Act, and the standards, rules, and regulations adopted hereunder, and provided that the health and safety of the patients of the hospital will be protected during the period for which such provisional license is issued. The Director shall advise the licensee of the conditions under which such provisional license is issued, including the manner in which the hospital facilities fail to comply with the provisions of the Act,

standards, rules, and regulations, and the time within which the changes and corrections necessary for such hospital facilities to substantially comply with this Act, and the standards, rules, and regulations of the Department relating thereto shall be completed.

(Source: P.A. 98-683, eff. 6-30-14.)

(210 ILCS 85/6.14c)

Sec. 6.14c. Posting of information. Every hospital shall conspicuously post, either by physical or electronic means, for display in an area of its offices accessible to patients, employees, and visitors the following:

(1) its current license;

(2) a description, provided by the Department, of complaint procedures established under this Act and the name, address, and telephone number of a person authorized by the Department to receive complaints;

(3) a list of any orders pertaining to the hospital issued by the Department during the past year and any court orders reviewing such Department orders issued during the past year; and

(4) a list of the material available for public inspection under Section 6.14d.

Each hospital shall post, either by physical or electronic means, in each facility that has an emergency room, a notice in a conspicuous location in the emergency room with information

about how to enroll in health insurance through the Illinois health insurance marketplace in accordance with Sections 1311 and 1321 of the federal Patient Protection and Affordable Care Act.

(Source: P.A. 101-117, eff. 1-1-20.)

(210 ILCS 85/10.10)

Sec. 10.10. Nurse Staffing by Patient Acuity.

(a) Findings. The Legislature finds and declares all of the following:

(1) The State of Illinois has a substantial interest in promoting quality care and improving the delivery of health care services.

(2) Evidence-based studies have shown that the basic principles of staffing in the acute care setting should be based on the complexity of patients' care needs aligned with available nursing skills to promote quality patient care consistent with professional nursing standards.

(3) Compliance with this Section promotes an organizational climate that values registered nurses' input in meeting the health care needs of hospital patients.

(b) Definitions. As used in this Section:

"Acuity model" means an assessment tool selected and implemented by a hospital, as recommended by a nursing care committee, that assesses the complexity of patient care needs

requiring professional nursing care and skills and aligns patient care needs and nursing skills consistent with professional nursing standards.

"Department" means the Department of Public Health.

"Direct patient care" means care provided by a registered professional nurse with direct responsibility to oversee or carry out medical regimens or nursing care for one or more patients.

"Nursing care committee" means an existing or newly created hospital-wide committee or committees of nurses whose functions, in part or in whole, contribute to the development, recommendation, and review of the hospital's nurse staffing plan established pursuant to subsection (d).

"Registered professional nurse" means a person licensed as a Registered Nurse under the Nurse Practice Act.

"Written staffing plan for nursing care services" means a written plan for guiding the assignment of patient care nursing staff based on multiple nurse and patient considerations that yield minimum staffing levels for inpatient care units and the adopted acuity model aligning patient care needs with nursing skills required for quality patient care consistent with professional nursing standards.

(c) Written staffing plan.

(1) Every hospital shall implement a written hospital-wide staffing plan, recommended by a nursing care committee or committees, that provides for minimum direct

care professional registered nurse-to-patient staffing needs for each inpatient care unit. The written hospital-wide staffing plan shall include, but need not be limited to, the following considerations:

(A) The complexity of complete care, assessment on patient admission, volume of patient admissions, discharges and transfers, evaluation of the progress of a patient's problems, ongoing physical assessments, planning for a patient's discharge, assessment after a change in patient condition, and assessment of the need for patient referrals.

(B) The complexity of clinical professional nursing judgment needed to design and implement a patient's nursing care plan, the need for specialized equipment and technology, the skill mix of other personnel providing or supporting direct patient care, and involvement in quality improvement activities, professional preparation, and experience.

(C) Patient acuity and the number of patients for whom care is being provided.

(D) The ongoing assessments of a unit's patient acuity levels and nursing staff needed shall be routinely made by the unit nurse manager or his or her designee.

(E) The identification of additional registered nurses available for direct patient care when

patients' unexpected needs exceed the planned workload for direct care staff.

(2) In order to provide staffing flexibility to meet patient needs, every hospital shall identify an acuity model for adjusting the staffing plan for each inpatient care unit.

(3) The written staffing plan shall be posted<u>, either by physical or electronic means,</u> in a conspicuous and accessible location for both patients and direct care staff, as required under the Hospital Report Card Act. A copy of the written staffing plan shall be provided to any member of the general public upon request.

(d) Nursing care committee.

(1) Every hospital shall have a nursing care committee. A hospital shall appoint members of a committee whereby at least 50% of the members are registered professional nurses providing direct patient care.

(2) A nursing care committee's recommendations must be given significant regard and weight in the hospital's adoption and implementation of a written staffing plan.

(3) A nursing care committee or committees shall recommend a written staffing plan for the hospital based on the principles from the staffing components set forth in subsection (c). In particular, a committee or committees shall provide input and feedback on the following:

(A) Selection, implementation, and evaluation of minimum staffing levels for inpatient care units.

(B) Selection, implementation, and evaluation of an acuity model to provide staffing flexibility that aligns changing patient acuity with nursing skills required.

(C) Selection, implementation, and evaluation of a written staffing plan incorporating the items described in subdivisions (c)(1) and (c)(2) of this Section.

(D) Review the following: nurse-to-patient staffing guidelines for all inpatient areas; and current acuity tools and measures in use.

(4) A nursing care committee must address the items described in subparagraphs (A) through (D) of paragraph (3) semi-annually.

(e) Nothing in this Section 10.10 shall be construed to limit, alter, or modify any of the terms, conditions, or provisions of a collective bargaining agreement entered into by the hospital.

(Source: P.A. 96-328, eff. 8-11-09; 97-423, eff. 1-1-12; 97-813, eff. 7-13-12.)

(210 ILCS 85/11.5)

Sec. 11.5. Uniform standards of obstetrical care regardless of ability to pay.

(a) No hospital may promulgate policies or implement practices that determine differing standards of obstetrical care based upon a patient's source of payment or ability to pay for medical services.

(b) Each hospital shall develop a written policy statement reflecting the requirements of subsection (a) and shall post, either by physical or electronic means, written notices of this policy in the obstetrical admitting areas of the hospital by July 1, 2004. Notices posted pursuant to this Section shall be posted in the predominant language or languages spoken in the hospital's service area.

(Source: P.A. 93-981, eff. 8-23-04.)

Section 15-10. The Language Assistance Services Act is amended by changing Section 15 as follows:

(210 ILCS 87/15)

Sec. 15. Language assistance services.

(a) To ensure access to health care information and services for limited-English-speaking or non-English-speaking residents and deaf residents, a health facility must do the following:

(1) Adopt and review annually a policy for providing language assistance services to patients with language or communication barriers. The policy shall include procedures for providing, to the extent possible as

determined by the facility, the use of an interpreter whenever a language or communication barrier exists, except where the patient, after being informed of the availability of the interpreter service, chooses to use a family member or friend who volunteers to interpret. The procedures shall be designed to maximize efficient use of interpreters and minimize delays in providing interpreters to patients. The procedures shall insure, to the extent possible as determined by the facility, that interpreters are available, either on the premises or accessible by telephone, 24 hours a day. The facility shall annually transmit to the Department of Public Health a copy of the updated policy and shall include a description of the facility's efforts to insure adequate and speedy communication between patients with language or communication barriers and staff.

(2) Develop, and post, either by physical or electronic means, in conspicuous locations, notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter, and the telephone numbers to call for filing complaints concerning interpreter service problems, including, but not limited to, a TTY number for persons who are deaf or hard of hearing. The notices shall be posted, at a minimum, in the emergency room, the admitting area, the facility entrance, and the outpatient area. Notices shall

inform patients that interpreter services are available on request, shall list the languages most commonly encountered at the facility for which interpreter services are available, and shall instruct patients to direct complaints regarding interpreter services to the Department of Public Health, including the telephone numbers to call for that purpose.

(3) Notify the facility's employees of the language services available at the facility and train them on how to make those language services available to patients.

(b) In addition, a health facility may do one or more of the following:

(1) Identify and record a patient's primary language and dialect on one or more of the following: a patient medical chart, hospital bracelet, bedside notice, or nursing card.

(2) Prepare and maintain, as needed, a list of interpreters who have been identified as proficient in sign language according to the Interpreter for the Deaf Licensure Act of 2007 and a list of the languages of the population of the geographical area served by the facility.

(3) Review all standardized written forms, waivers, documents, and informational materials available to patients on admission to determine which to translate into languages other than English.

(4) Consider providing its nonbilingual staff with standardized picture and phrase sheets for use in routine communications with patients who have language or communication barriers.

(5) Develop community liaison groups to enable the facility and the limited-English-speaking, non-English-speaking, and deaf communities to ensure the adequacy of the interpreter services.

(Source: P.A. 98-756, eff. 7-16-14.)

Section 15-15. The Fair Patient Billing Act is amended by changing Section 15 as follows:

(210 ILCS 88/15)

Sec. 15. Patient notification.

(a) Each hospital shall post a sign with the following notice:

"You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information contact [hospital financial assistance representative]".

(b) The sign under subsection (a) shall be posted<u>, either by physical or electronic means,</u> conspicuously in the admission and registration areas of the hospital.

(c) The sign shall be in English, and in any other language that is the primary language of at least 5% of the patients

served by the hospital annually.

(d) Each hospital that has a website must post a notice in a prominent place on its website that financial assistance is available at the hospital, a description of the financial assistance application process, and a copy of the financial assistance application.

(e) Within 180 days after the effective date of this amendatory Act of the 102nd General Assembly, each ~~Each~~ hospital must make available information regarding financial assistance from the hospital in the form of either a brochure, an application for financial assistance, or other written or electronic material in the emergency room, ~~material in the~~ hospital admission, or registration area.

(Source: P.A. 94-885, eff. 1-1-07.)

Section 15-16. The Health Care Violence Prevention Act is amended by changing Section 15 as follows:

(210 ILCS 160/15)

Sec. 15. Workplace safety.

(a) A health care worker who contacts law enforcement or files a report with law enforcement against a patient or individual because of workplace violence shall provide notice to management of the health care provider by which he or she is employed within 3 days after contacting law enforcement or filing the report.

(b) No management of a health care provider may discourage a health care worker from exercising his or her right to contact law enforcement or file a report with law enforcement because of workplace violence.

(c) A health care provider that employs a health care worker shall display a notice, either by physical or electronic means, stating that verbal aggression will not be tolerated and physical assault will be reported to law enforcement.

(d) The health care provider shall offer immediate post-incident services for a health care worker directly involved in a workplace violence incident caused by patients or their visitors, including acute treatment and access to psychological evaluation.

(Source: P.A. 100-1051, eff. 1-1-19.)

Section 15-17. The Medical Patient Rights Act is amended by changing Sections 3.4 and 5.2 as follows:

(410 ILCS 50/3.4)

Sec. 3.4. Rights of women; pregnancy and childbirth.

(a) In addition to any other right provided under this Act, every woman has the following rights with regard to pregnancy and childbirth:

(1) The right to receive health care before, during, and after pregnancy and childbirth.

(2) The right to receive care for her and her infant that is consistent with generally accepted medical standards.

(3) The right to choose a certified nurse midwife or physician as her maternity care professional.

(4) The right to choose her birth setting from the full range of birthing options available in her community.

(5) The right to leave her maternity care professional and select another if she becomes dissatisfied with her care, except as otherwise provided by law.

(6) The right to receive information about the names of those health care professionals involved in her care.

(7) The right to privacy and confidentiality of records, except as provided by law.

(8) The right to receive information concerning her condition and proposed treatment, including methods of relieving pain.

(9) The right to accept or refuse any treatment, to the extent medically possible.

(10) The right to be informed if her caregivers wish to enroll her or her infant in a research study in accordance with Section 3.1 of this Act.

(11) The right to access her medical records in accordance with Section 8-2001 of the Code of Civil Procedure.

(12) The right to receive information in a language in

which she can communicate in accordance with federal law.

(13) The right to receive emotional and physical support during labor and birth.

(14) The right to freedom of movement during labor and to give birth in the position of her choice, within generally accepted medical standards.

(15) The right to contact with her newborn, except where necessary care must be provided to the mother or infant.

(16) The right to receive information about breastfeeding.

(17) The right to decide collaboratively with caregivers when she and her baby will leave the birth site for home, based on their conditions and circumstances.

(18) The right to be treated with respect at all times before, during, and after pregnancy by her health care professionals.

(19) The right of each patient, regardless of source of payment, to examine and receive a reasonable explanation of her total bill for services rendered by her maternity care professional or health care provider, including itemized charges for specific services received. Each maternity care professional or health care provider shall be responsible only for a reasonable explanation of those specific services provided by the maternity care professional or health care provider.

(b) The Department of Public Health, Department of Healthcare and Family Services, Department of Children and Family Services, and Department of Human Services shall post, either by physical or electronic means, information about these rights on their publicly available websites. Every health care provider, day care center licensed under the Child Care Act of 1969, Head Start, and community center shall post information about these rights in a prominent place and on their websites, if applicable.

(c) The Department of Public Health shall adopt rules to implement this Section.

(d) Nothing in this Section or any rules adopted under subsection (c) shall be construed to require a physician, health care professional, hospital, hospital affiliate, or health care provider to provide care inconsistent with generally accepted medical standards or available capabilities or resources.

(Source: P.A. 101-445, eff. 1-1-20.)

(410 ILCS 50/5.2)

Sec. 5.2. Emergency room anti-discrimination notice. Every hospital shall post, either by physical or electronic means, a sign next to or in close proximity of its sign required by Section 489.20 (q)(1) of Title 42 of the Code of Federal Regulations stating the following:

"You have the right not to be discriminated against by the

hospital due to your race, color, or national origin if these characteristics are unrelated to your diagnosis or treatment. If you believe this right has been violated, please call (insert number for hospital grievance officer).".

(Source: P.A. 97-485, eff. 8-22-11.)

Section 15-25. The Abandoned Newborn Infant Protection Act is amended by changing Section 22 as follows:

(325 ILCS 2/22)

Sec. 22. Signs. Every hospital, fire station, emergency medical facility, and police station that is required to accept a relinquished newborn infant in accordance with this Act must post<u>, either by physical or electronic means,</u> a sign in a conspicuous place on the exterior of the building housing the facility informing persons that a newborn infant may be relinquished at the facility in accordance with this Act. The Department shall prescribe specifications for the signs and for their placement that will ensure statewide uniformity.

This Section does not apply to a hospital, fire station, emergency medical facility, or police station that has a sign that is consistent with the requirements of this Section that is posted on the effective date of this amendatory Act of the 95th General Assembly.

(Source: P.A. 95-275, eff. 8-17-07.)

Section 15-30. The Crime Victims Compensation Act is amended by changing Section 5.1 as follows:

(740 ILCS 45/5.1) (from Ch. 70, par. 75.1)

Sec. 5.1. (a) Every hospital licensed under the laws of this State shall display prominently in its emergency room posters giving notification of the existence and general provisions of this Act. The posters may be displayed by physical or electronic means. Such posters shall be provided by the Attorney General.

(b) Any law enforcement agency that investigates an offense committed in this State shall inform the victim of the offense or his dependents concerning the availability of an award of compensation and advise such persons that any information concerning this Act and the filing of a claim may be obtained from the office of the Attorney General.

(Source: P.A. 81-1013.)

Section 15-35. The Human Trafficking Resource Center Notice Act is amended by changing Sections 5 and 10 as follows:

(775 ILCS 50/5)

Sec. 5. Posted notice required.

(a) Each of the following businesses and other establishments shall, upon the availability of the model notice described in Section 15 of this Act, post a notice that

complies with the requirements of this Act in a conspicuous place near the public entrance of the establishment or in another conspicuous location in clear view of the public and employees where similar notices are customarily posted:

(1) On premise consumption retailer licensees under the Liquor Control Act of 1934 where the sale of alcoholic liquor is the principal business carried on by the licensee at the premises and primary to the sale of food.

(2) Adult entertainment facilities, as defined in Section 5-1097.5 of the Counties Code.

(3) Primary airports, as defined in Section 47102(16) of Title 49 of the United States Code.

(4) Intercity passenger rail or light rail stations.

(5) Bus stations.

(6) Truck stops. For purposes of this Act, "truck stop" means a privately-owned and operated facility that provides food, fuel, shower or other sanitary facilities, and lawful overnight truck parking.

(7) Emergency rooms within general acute care hospitals<u>, in which case the notice may be posted by electronic means</u>.

(8) Urgent care centers<u>, in which case the notice may be posted by electronic means</u>.

(9) Farm labor contractors. For purposes of this Act, "farm labor contractor" means: (i) any person who for a fee or other valuable consideration recruits, supplies, or

hires, or transports in connection therewith, into or within the State, any farmworker not of the contractor's immediate family to work for, or under the direction, supervision, or control of, a third person; or (ii) any person who for a fee or other valuable consideration recruits, supplies, or hires, or transports in connection therewith, into or within the State, any farmworker not of the contractor's immediate family, and who for a fee or other valuable consideration directs, supervises, or controls all or any part of the work of the farmworker or who disburses wages to the farmworker. However, "farm labor contractor" does not include full-time regular employees of food processing companies when the employees are engaged in recruiting for the companies if those employees are not compensated according to the number of farmworkers they recruit.

(10) Privately-operated job recruitment centers.

(11) Massage establishments. As used in this Act, "massage establishment" means a place of business in which any method of massage therapy is administered or practiced for compensation. "Massage establishment" does not include: an establishment at which persons licensed under the Medical Practice Act of 1987, the Illinois Physical Therapy Act, or the Naprapathic Practice Act engage in practice under one of those Acts; a business owned by a sole licensed massage therapist; or a cosmetology or

esthetics salon registered under the Barber, Cosmetology, Esthetics, Hair Braiding, and Nail Technology Act of 1985.

(b) The Department of Transportation shall, upon the availability of the model notice described in Section 15 of this Act, post a notice that complies with the requirements of this Act in a conspicuous place near the public entrance of each roadside rest area or in another conspicuous location in clear view of the public and employees where similar notices are customarily posted.

(c) The owner of a hotel or motel shall, upon the availability of the model notice described in Section 15 of this Act, post a notice that complies with the requirements of this Act in a conspicuous and accessible place in or about the premises in clear view of the employees where similar notices are customarily posted.

(d) The organizer of a public gathering or special event that is conducted on property open to the public and requires the issuance of a permit from the unit of local government shall post a notice that complies with the requirements of this Act in a conspicuous and accessible place in or about the premises in clear view of the public and employees where similar notices are customarily posted.

(e) The administrator of a public or private elementary school or public or private secondary school shall post a printout of the downloadable notice provided by the Department of Human Services under Section 15 that complies with the

requirements of this Act in a conspicuous and accessible place chosen by the administrator in the administrative office or another location in view of school employees. School districts and personnel are not subject to the penalties provided under subsection (a) of Section 20.

(f) The owner of an establishment registered under the Tattoo and Body Piercing Establishment Registration Act shall post a notice that complies with the requirements of this Act in a conspicuous and accessible place in clear view of establishment employees.

(Source: P.A. 99-99, eff. 1-1-16; 99-565, eff. 7-1-17; 100-671, eff. 1-1-19.)

(775 ILCS 50/10)

Sec. 10. Form of posted notice.

(a) The notice required under this Act shall be at least 8 1/2 inches by 11 inches in size, written in a 16-point font, except that when the notice is provided by electronic means the size of the notice and font shall not be required to comply with these specifications, and shall state the following:

"If you or someone you know is being forced to engage in any activity and cannot leave, whether it is commercial sex, housework, farm work, construction, factory, retail, or restaurant work, or any other activity, call the National Human Trafficking Resource Center at 1-888-373-7888 to access

help and services.

Victims of slavery and human trafficking are protected under United States and Illinois law. The hotline is:

* Available 24 hours a day, 7 days a week.

* Toll-free.

* Operated by nonprofit nongovernmental organizations.

* Anonymous and confidential.

* Accessible in more than 160 languages.

* Able to provide help, referral to services, training, and general information.".

(b) The notice shall be printed in English, Spanish, and in one other language that is the most widely spoken language in the county where the establishment is located and for which translation is mandated by the federal Voting Rights Act, as applicable. This subsection does not require a business or other establishment in a county where a language other than English or Spanish is the most widely spoken language to print the notice in more than one language in addition to English and Spanish.

(Source: P.A. 99-99, eff. 1-1-16.)

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. Pursuant to and in accordance with applicable local, State, and federal policies, guidance and recommendations of public health and infection control authorities, and taking into consideration the limitations on access to N95 masks caused by disruptions in local, State, national, and international supply chains, the University of Illinois Hospital shall provide N95 masks to physicians licensed under the Medical Practice Act of 1987, registered nurses and advanced practice registered nurses licensed under the Nurse Licensing Act, and any other employees or contractual workers who provide direct patient care and who, pursuant to such policies, guidance, and recommendations, are recommended to have such a mask to safely provide such direct patient care within a hospital setting. Nothing in this Section shall be construed to impose any new duty or obligation on the University of Illinois Hospital or employee that is greater than that imposed under State and federal laws in effect on the effective date of this amendatory Act of the 102nd General Assembly. This Section is repealed on December 31, 2021.

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. Pursuant to and in accordance with applicable local, State, and federal policies, guidance and recommendations of public health and infection control authorities, and taking into consideration the limitations on access to N95 masks caused by disruptions in local, State, national, and international supply chains, a hospital licensed under this Act shall provide N95 masks to physicians licensed under the Medical Practice Act of 1987, registered nurses and advanced practice registered nurses licensed under the Nurse Licensing Act, and any other employees or contractual workers who provide direct patient care and who, pursuant to such policies, guidance, and recommendations, are recommended to have such a mask to safely provide such direct patient care within a hospital setting. Nothing in this Section shall be construed to impose any new duty or obligation on the hospital or employee that is greater than that imposed under State and federal laws in effect on the effective date of this amendatory Act of the 102nd General Assembly. This Section is repealed on December 31, 2021.

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, and subject to appropriation, the inpatient, per diem rate to be paid to all 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 45-5. The Department of Professional Regulation Law of the Civil Administrative Code of Illinois is amended by adding Section 2105-15.7 as follows:

(20 ILCS 2105/2105-15.7 new)

Sec. 2105-15.7. Implicit bias awareness training.

(a) As used in this Section, "health care professional" means a person licensed or registered by the Department of Financial and Professional Regulation under the following Acts: Medical Practice Act of 1987, Nurse Practice Act, Clinical Psychologist Licensing Act, Illinois Dental Practice Act, Illinois Optometric Practice Act of 1987, Pharmacy Practice Act, Illinois Physical Therapy Act, Physician Assistant Practice Act of 1987, Acupuncture Practice Act, Illinois Athletic Trainers Practice Act, Clinical Social Work and Social Work Practice Act, Dietitian Nutritionist Practice Act, Home Medical Equipment and Services Provider License Act, Naprapathic Practice Act, Nursing Home Administrators

Licensing and Disciplinary Act, Illinois Occupational Therapy Practice Act, Illinois Optometric Practice Act of 1987, Podiatric Medical Practice Act of 1987, Respiratory Care Practice Act, Professional Counselor and Clinical Professional Counselor Licensing and Practice Act, Sex Offender Evaluation and Treatment Provider Act, Illinois Speech-Language Pathology and Audiology Practice Act, Perfusionist Practice Act, Registered Surgical Assistant and Registered Surgical Technologist Title Protection Act, and Genetic Counselor Licensing Act.

(b) For license or registration renewals occurring on or after January 1, 2022, a health care professional who has continuing education requirements must complete at least a one-hour course in training on implicit bias awareness per renewal period. A health care professional may count this one hour for completion of this course toward meeting the minimum credit hours required for continuing education. Any training on implicit bias awareness applied to meet any other State licensure requirement, professional accreditation or certification requirement, or health care institutional practice agreement may count toward the one-hour requirement under this Section.

(c) The Department may adopt rules for the implementation of this Section.

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, 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, 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 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.)

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, 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, 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. Findings. The General Assembly finds that:

(1) Prior to August of 2020, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the federal Confidentiality of Substance Use Disorder

Patient Records, set forth at 42 CFR 2, prohibited the sharing of substance use disorder treatment information by opioid treatment programs with prescription monitoring programs.

(2) In August 2020, SAMHSA amended 42 CFR 2 to permit the sharing of substance use disorder treatment information by opioid treatment programs with prescription monitoring programs if required by State law and if patient consent is obtained. In light of the federal modification to 42 CFR 2, the protections available under federal and State law, and the express requirement of patient consent, the reporting by opioid treatment programs to the prescription monitoring program is permitted and will allow for better coordination of care among treating providers.

Section 55-10. 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 licensed or certified by the Department of Human Services' Division of Substance Use Prevention and Recovery and that are authorized by the federal Drug Enforcement Administration to prescribe Schedule II, III, IV, or V controlled substances for the treatment of opioid use disorder. Opioid treatment programs may not transmit information without patient consent, and reports made may not be utilized for law enforcement purposes, each as proscribed by 42 CFR 2, as amended by 42 U.S.C. 290dd-2.

Treatment of a patient may not be conditioned upon his or her consent to reporting.

(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 and 42 CFR Part 2 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, subject to appropriation.

(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.

Article 65.

Section 65-1. Short title. This Article may be cited as the Behavioral Health Workforce Education Center of Illinois

Act. References in this Article to "this Act" mean this Article.

Section 65-5. Findings. The General Assembly finds as follows:

(1) There are insufficient behavioral health professionals in this State's behavioral health workforce and further that there are insufficient behavioral health professionals trained in evidence-based practices.

(2) The Illinois behavioral health workforce situation is at a crisis state and the lack of a behavioral health strategy is exacerbating the problem.

(3) In 2019, the Journal of Community Health found that suicide rates are disproportionately higher among African American adolescents. From 2001 to 2017, the rate for African American teen boys rose 60%, according to the study. Among African American teen girls, rates nearly tripled, rising by an astounding 182%. Illinois was among the 10 states with the greatest number of African American adolescent suicides (2015-2017).

(4) Workforce shortages are evident in all behavioral health professions, including, but not limited to, psychiatry, psychiatric nursing, psychiatric physician assistant, social work (licensed social work, licensed clinical social work), counseling (licensed professional counseling, licensed clinical professional counseling),

marriage and family therapy, licensed clinical psychology, occupational therapy, prevention, substance use disorder counseling, and peer support.

(5) The shortage of behavioral health practitioners affects every Illinois county, every group of people with behavioral health needs, including children and adolescents, justice-involved populations, working adults, people experiencing homelessness, veterans, and older adults, and every health care and social service setting, from residential facilities and hospitals to community-based organizations and primary care clinics.

(6) Estimates of unmet needs consistently highlight the dire situation in Illinois. Mental Health America ranks Illinois 29th in the country in mental health workforce availability based on its 480-to-1 ratio of population to mental health professionals, and the Kaiser Family Foundation estimates that only 23.3% of Illinoisans' mental health needs can be met with its current workforce.

(7) Shortages are especially acute in rural areas and among low-income and under-insured individuals and families. 30.3% of Illinois' rural hospitals are in designated primary care shortage areas and 93.7% are in designated mental health shortage areas. Nationally, 40% of psychiatrists work in cash-only practices, limiting access for those who cannot afford high out-of-pocket

costs, especially Medicaid eligible individuals and families.

(8) Spanish-speaking therapists in suburban Cook County, as well as in immigrant new growth communities throughout the State, for example, and master's-prepared social workers in rural communities are especially difficult to recruit and retain.

(9) Illinois' shortage of psychiatrists specializing in serving children and adolescents is also severe. Eighty-one out of 102 Illinois counties have no child and adolescent psychiatrists, and the remaining 21 counties have only 310 child and adolescent psychiatrists for a population of 2,450,000 children.

(10) Only 38.9% of the 121,000 Illinois youth aged 12 through 17 who experienced a major depressive episode received care.

(11) An annual average of 799,000 people in Illinois aged 12 and older need but do not receive substance use disorder treatment at specialty facilities.

(12) According to the Statewide Semiannual Opioid Report, Illinois Department of Public Health, September 2020, the number of opioid deaths in Illinois has increased 3% from 2,167 deaths in 2018 to 2,233 deaths in 2019.

(13) Behavioral health workforce shortages have led to well-documented problems of long wait times for

appointments with psychiatrists (4 to 6 months in some cases), high turnover, and unfilled vacancies for social workers and other behavioral health professionals that have eroded the gains in insurance coverage for mental illness and substance use disorder under the federal Affordable Care Act and parity laws.

(14) As a result, individuals with mental illness or substance use disorders end up in hospital emergency rooms, which are the most expensive level of care, or are incarcerated and do not receive adequate care, if any.

(15) There are many organizations and institutions that are affected by behavioral health workforce shortages, but no one entity is responsible for monitoring the workforce supply and intervening to ensure it can effectively meet behavioral health needs throughout the State.

(16) Workforce shortages are more complex than simple numerical shortfalls. Identifying the optimal number, type, and location of behavioral health professionals to meet the differing needs of Illinois' diverse regions and populations across the lifespan is a difficult logistical problem at the system and practice level that requires coordinated efforts in research, education, service delivery, and policy.

(17) This State has a compelling and substantial interest in building a pipeline for behavioral health

professionals and to anchor research and education for behavioral health workforce development. Beginning with the proposed Behavioral Health Workforce Education Center of Illinois, Illinois has the chance to develop a blueprint to be a national leader in behavioral health workforce development.

(18) The State must act now to improve the ability of its residents to achieve their human potential and to live healthy, productive lives by reducing the misery and suffering with unmet behavioral health needs.

Section 65-10. Behavioral Health Workforce Education Center of Illinois.

(a) The Behavioral Health Workforce Education Center of Illinois is created and shall be administered by a teaching, research, or both teaching and research public institution of higher education in this State. Subject to appropriation, the Center shall be operational on or before July 1, 2022.

(b) The Behavioral Health Workforce Education Center of Illinois shall leverage workforce and behavioral health resources, including, but not limited to, State, federal, and foundation grant funding, federal Workforce Investment Act of 1998 programs, the National Health Service Corps and other nongraduate medical education physician workforce training programs, and existing behavioral health partnerships, and align with reforms in Illinois.

Section 65-15. Structure.

(a) The Behavioral Health Workforce Education Center of Illinois shall be structured as a multisite model, and the administering public institution of higher education shall serve as the hub institution, complemented by secondary regional hubs, namely academic institutions, that serve rural and small urban areas and at least one academic institution serving a densely urban municipality with more than 1,000,000 inhabitants.

(b) The Behavioral Health Workforce Education Center of Illinois shall be located within one academic institution and shall be tasked with a convening and coordinating role for workforce research and planning, including monitoring progress toward Center goals.

(c) The Behavioral Health Workforce Education Center of Illinois shall also coordinate with key State agencies involved in behavioral health, workforce development, and higher education in order to leverage disparate resources from health care, workforce, and economic development programs in Illinois government.

Section 65-20. Duties. The Behavioral Health Workforce Education Center of Illinois shall perform the following duties:

(1) Organize a consortium of universities in

partnerships with providers, school districts, law enforcement, consumers and their families, State agencies, and other stakeholders to implement workforce development concepts and strategies in every region of this State.

(2) Be responsible for developing and implementing a strategic plan for the recruitment, education, and retention of a qualified, diverse, and evolving behavioral health workforce in this State. Its planning and activities shall include:

(A) convening and organizing vested stakeholders spanning government agencies, clinics, behavioral health facilities, prevention programs, hospitals, schools, jails, prisons and juvenile justice, police and emergency medical services, consumers and their families, and other stakeholders;

(B) collecting and analyzing data on the behavioral health workforce in Illinois, with detailed information on specialties, credentials, additional qualifications (such as training or experience in particular models of care), location of practice, and demographic characteristics, including age, gender, race and ethnicity, and languages spoken;

(C) building partnerships with school districts, public institutions of higher education, and workforce investment agencies to create pipelines to behavioral health careers from high schools and colleges,

pathways to behavioral health specialization among health professional students, and expanded behavioral health residency and internship opportunities for graduates;

(D) evaluating and disseminating information about evidence-based practices emerging from research regarding promising modalities of treatment, care coordination models, and medications;

(E) developing systems for tracking the utilization of evidence-based practices that most effectively meet behavioral health needs; and

(F) providing technical assistance to support professional training and continuing education programs that provide effective training in evidence-based behavioral health practices.

(3) Coordinate data collection and analysis, including systematic tracking of the behavioral health workforce and datasets that support workforce planning for an accessible, high-quality behavioral health system. In the medium to long-term, the Center shall develop Illinois behavioral workforce data capacity by:

(A) filling gaps in workforce data by collecting information on specialty, training, and qualifications for specific models of care, demographic characteristics, including gender, race, ethnicity, and languages spoken, and participation in public and

private insurance networks;

(B) identifying the highest priority geographies, populations, and occupations for recruitment and training;

(C) monitoring the incidence of behavioral health conditions to improve estimates of unmet need; and

(D) compiling up-to-date, evidence-based practices, monitoring utilization, and aligning training resources to improve the uptake of the most effective practices.

(4) Work to grow and advance peer and parent-peer workforce development by:

(A) assessing the credentialing and reimbursement processes and recommending reforms;

(B) evaluating available peer-parent training models, choosing a model that meets Illinois' needs, and working with partners to implement it universally in child-serving programs throughout this State; and

(C) including peer recovery specialists and parent-peer support professionals in interdisciplinary training programs.

(5) Focus on the training of behavioral health professionals in telehealth techniques, including taking advantage of a telehealth network that exists, and other innovative means of care delivery in order to increase access to behavioral health services for all persons

within this State.

(6) No later than December 1 of every odd-numbered year, prepare a report of its activities under this Act. The report shall be filed electronically with the General Assembly, as provided under Section 3.1 of the General Assembly Organization Act, and shall be provided electronically to any member of the General Assembly upon request.

Section 65-25. Selection process.

(a) No later than 90 days after the effective date of this Act, the Board of Higher Education shall select a public institution of higher education, with input and assistance from the Division of Mental Health of the Department of Human Services, to administer the Behavioral Health Workforce Education Center of Illinois.

(b) The selection process shall articulate the principles of the Behavioral Health Workforce Education Center of Illinois, not inconsistent with this Act.

(c) The Board of Higher Education, with input and assistance from the Division of Mental Health of the Department of Human Services, shall make its selection of a public institution of higher education based on its ability and willingness to execute the following tasks:

(1) Convening academic institutions providing behavioral health education to:

(A) develop curricula to train future behavioral health professionals in evidence-based practices that meet the most urgent needs of Illinois' residents;

(B) build capacity to provide clinical training and supervision; and

(C) facilitate telehealth services to every region of the State.

(2) Functioning as a clearinghouse for research, education, and training efforts to identify and disseminate evidence-based practices across the State.

(3) Leveraging financial support from grants and social impact loan funds.

(4) Providing infrastructure to organize regional behavioral health education and outreach. As budgets allow, this shall include conference and training space, research and faculty staff time, telehealth, and distance learning equipment.

(5) Working with regional hubs that assess and serve the workforce needs of specific, well-defined regions and specialize in specific research and training areas, such as telehealth or mental health-criminal justice partnerships, for which the regional hub can serve as a statewide leader.

(d) The Board of Higher Education may adopt such rules as may be necessary to implement and administer 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 72.

Section 72-1. Short title. This Article may be cited as the Underlying Causes of Crime and Violence Study Act.

Section 72-5. Legislative findings. In the State of Illinois, two-thirds of gun violence is related to suicide, and one-third is related to homicide, claiming approximately 12,000 lives a year. Violence has plagued communities, predominantly poor and distressed communities in urban settings, which have always treated violence as a criminal justice issue, instead of a public health issue. On February 21, 2018, Pastor Anthony Williams was informed that his son, Nehemiah William, had been shot to death. Due to this disheartening event, Pastor Anthony Williams reached out to State Representative Elizabeth "Lisa" Hernandez, urging that the issue of violence be treated as a public health crisis. In 2018, elected officials from all levels of government started a coalition to address violence as a public health crisis, with the assistance of faith-based organizations, advocates, and community members and held a statewide listening tour from August 2018 to April 2019. The listening tour consisted of stops on the South Side and West Side of Chicago, Maywood, Springfield, and East St. Louis, with a future scheduled visit in Danville. During the statewide listening sessions, community members actively discussed neighborhood safety, defining violence and how and why violence occurs in their communities. The listening sessions provided different solutions to address violence, however, all sessions confirmed a disconnect from the priorities of government and the needs

of these communities.

Section 72-10. Study. The Department of Public Health and the Department of Human Services shall study how to create a process to identify high violence communities, also known as R3 (Restore, Reinvest, and Renew) areas, and prioritize State dollars to go to these communities to fund programs as well as community and economic development projects that would address the underlying causes of crime and violence.

Due to a variety of reasons, including in particular the State's budget impasse, funds from multiple sources to establish such a comprehensive policy are subject to appropriation. Private philanthropic efforts will also be considered. Policies like R3 are needed in order to provide communities that have historically suffered from divestment, poverty, and incarceration with smart solutions that can solve the plague of structural violence that includes collective, interpersonal, and self-directed violence. Understanding structural violence helps explain the multiple and often intersecting forces that create and perpetuate these conditions on multiple levels. It is clear that violence is a public health problem that needs to be treated as such. Research has shown that when violence is treated in such a way that educates, fosters collaboration, and redirects the funding on a governmental level, its effects can be slowed or even halted, resulting in civility being brought to our

communities in the State of Illinois. Research has shown that when violence is treated in such a way, then its effects can be slowed or even halted.

Section 72-15. Report. The Department of Public Health and the Department of Human Services are required to report their findings to the General Assembly by December 31, 2021.

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:

"Covered family member" means an employee's child, stepchild, spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent.

"Department" means the Department of Labor.

"Personal care" means activities to ensure that a covered family member's basic medical, hygiene, nutritional, or safety needs are met, or to provide transportation to medical appointments, for a covered family member who is unable to meet those needs himself or herself. "Personal care" also means being physically present to provide emotional support to

a covered family member with a serious health condition who is receiving inpatient or home care.

"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 personal care of a covered family member. 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 personal care of a covered family member 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, or personal care of the employee's covered family member ~~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 Legionella bacteria. A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests shall be made available to the Department upon request.

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 Legionella bacteria. A hospital shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests shall be made available to the Department upon request.

Article 95.

Section 95-5. The Child Care Act of 1969 is amended by changing Section 7 as follows:

(225 ILCS 10/7) (from Ch. 23, par. 2217)

Sec. 7. (a) The Department must prescribe and publish minimum standards for licensing that apply to the various

types of facilities for child care defined in this Act and that are equally applicable to like institutions under the control of the Department and to foster family homes used by and under the direct supervision of the Department. The Department shall seek the advice and assistance of persons representative of the various types of child care facilities in establishing such standards. The standards prescribed and published under this Act take effect as provided in the Illinois Administrative Procedure Act, and are restricted to regulations pertaining to the following matters and to any rules and regulations required or permitted by any other Section of this Act:

(1) The operation and conduct of the facility and responsibility it assumes for child care;

(2) The character, suitability and qualifications of the applicant and other persons directly responsible for the care and welfare of children served. All child day care center licensees and employees who are required to report child abuse or neglect under the Abused and Neglected Child Reporting Act shall be required to attend training on recognizing child abuse and neglect, as prescribed by Department rules;

(3) The general financial ability and competence of the applicant to provide necessary care for children and to maintain prescribed standards;

(4) The number of individuals or staff required to

insure adequate supervision and care of the children received. The standards shall provide that each child care institution, maternity center, day care center, group home, day care home, and group day care home shall have on its premises during its hours of operation at least one staff member certified in first aid, in the Heimlich maneuver and in cardiopulmonary resuscitation by the American Red Cross or other organization approved by rule of the Department. Child welfare agencies shall not be subject to such a staffing requirement. The Department may offer, or arrange for the offering, on a periodic basis in each community in this State in cooperation with the American Red Cross, the American Heart Association or other appropriate organization, voluntary programs to train operators of foster family homes and day care homes in first aid and cardiopulmonary resuscitation;

(5) The appropriateness, safety, cleanliness, and general adequacy of the premises, including maintenance of adequate fire prevention and health standards conforming to State laws and municipal codes to provide for the physical comfort, care, and well-being of children received;

(6) Provisions for food, clothing, educational opportunities, program, equipment and individual supplies to assure the healthy physical, mental, and spiritual development of children served;

(7) Provisions to safeguard the legal rights of children served;

(8) Maintenance of records pertaining to the admission, progress, health, and discharge of children, including, for day care centers and day care homes, records indicating each child has been immunized as required by State regulations. The Department shall require proof that children enrolled in a facility have been immunized against Haemophilus Influenzae B (HIB);

(9) Filing of reports with the Department;

(10) Discipline of children;

(11) Protection and fostering of the particular religious faith of the children served;

(12) Provisions prohibiting firearms on day care center premises except in the possession of peace officers;

(13) Provisions prohibiting handguns on day care home premises except in the possession of peace officers or other adults who must possess a handgun as a condition of employment and who reside on the premises of a day care home;

(14) Provisions requiring that any firearm permitted on day care home premises, except handguns in the possession of peace officers, shall be kept in a disassembled state, without ammunition, in locked storage, inaccessible to children and that ammunition permitted on

day care home premises shall be kept in locked storage separate from that of disassembled firearms, inaccessible to children;

(15) Provisions requiring notification of parents or guardians enrolling children at a day care home of the presence in the day care home of any firearms and ammunition and of the arrangements for the separate, locked storage of such firearms and ammunition;

(16) Provisions requiring all licensed child care facility employees who care for newborns and infants to complete training every 3 years on the nature of sudden unexpected infant death (SUID), sudden infant death syndrome (SIDS), and the safe sleep recommendations of the American Academy of Pediatrics; and

(17) With respect to foster family homes, provisions requiring the Department to review quality of care concerns and to consider those concerns in determining whether a foster family home is qualified to care for children.

By July 1, 2022, all licensed day care home providers, licensed group day care home providers, and licensed day care center directors and classroom staff shall participate in at least one training that includes the topics of early childhood social emotional learning, infant and early childhood mental health, early childhood trauma, or adverse childhood experiences. Current licensed providers, directors, and

classroom staff shall complete training by July 1, 2022 and shall participate in training that includes the above topics at least once every 3 years.

(b) If, in a facility for general child care, there are children diagnosed as mentally ill or children diagnosed as having an intellectual or physical disability, who are determined to be in need of special mental treatment or of nursing care, or both mental treatment and nursing care, the Department shall seek the advice and recommendation of the Department of Human Services, the Department of Public Health, or both Departments regarding the residential treatment and nursing care provided by the institution.

(c) The Department shall investigate any person applying to be licensed as a foster parent to determine whether there is any evidence of current drug or alcohol abuse in the prospective foster family. The Department shall not license a person as a foster parent if drug or alcohol abuse has been identified in the foster family or if a reasonable suspicion of such abuse exists, except that the Department may grant a foster parent license to an applicant identified with an alcohol or drug problem if the applicant has successfully participated in an alcohol or drug treatment program, self-help group, or other suitable activities and if the Department determines that the foster family home can provide a safe, appropriate environment and meet the physical and emotional needs of children.

(d) The Department, in applying standards prescribed and published, as herein provided, shall offer consultation through employed staff or other qualified persons to assist applicants and licensees in meeting and maintaining minimum requirements for a license and to help them otherwise to achieve programs of excellence related to the care of children served. Such consultation shall include providing information concerning education and training in early childhood development to providers of day care home services. The Department may provide or arrange for such education and training for those providers who request such assistance.

(e) The Department shall distribute copies of licensing standards to all licensees and applicants for a license. Each licensee or holder of a permit shall distribute copies of the appropriate licensing standards and any other information required by the Department to child care facilities under its supervision. Each licensee or holder of a permit shall maintain appropriate documentation of the distribution of the standards. Such documentation shall be part of the records of the facility and subject to inspection by authorized representatives of the Department.

(f) The Department shall prepare summaries of day care licensing standards. Each licensee or holder of a permit for a day care facility shall distribute a copy of the appropriate summary and any other information required by the Department, to the legal guardian of each child cared for in that facility

at the time when the child is enrolled or initially placed in the facility. The licensee or holder of a permit for a day care facility shall secure appropriate documentation of the distribution of the summary and brochure. Such documentation shall be a part of the records of the facility and subject to inspection by an authorized representative of the Department.

(g) The Department shall distribute to each licensee and holder of a permit copies of the licensing or permit standards applicable to such person's facility. Each licensee or holder of a permit shall make available by posting at all times in a common or otherwise accessible area a complete and current set of licensing standards in order that all employees of the facility may have unrestricted access to such standards. All employees of the facility shall have reviewed the standards and any subsequent changes. Each licensee or holder of a permit shall maintain appropriate documentation of the current review of licensing standards by all employees. Such records shall be part of the records of the facility and subject to inspection by authorized representatives of the Department.

(h) Any standards involving physical examinations, immunization, or medical treatment shall include appropriate exemptions for children whose parents object thereto on the grounds that they conflict with the tenets and practices of a recognized church or religious organization, of which the parent is an adherent or member, and for children who should not be subjected to immunization for clinical reasons.

(i) The Department, in cooperation with the Department of Public Health, shall work to increase immunization awareness and participation among parents of children enrolled in day care centers and day care homes by publishing on the Department's website information about the benefits of immunization against vaccine preventable diseases, including influenza and pertussis. The information for vaccine preventable diseases shall include the incidence and severity of the diseases, the availability of vaccines, and the importance of immunizing children and persons who frequently have close contact with children. The website content shall be reviewed annually in collaboration with the Department of Public Health to reflect the most current recommendations of the Advisory Committee on Immunization Practices (ACIP). The Department shall work with day care centers and day care homes licensed under this Act to ensure that the information is annually distributed to parents in August or September.

(j) Any standard adopted by the Department that requires an applicant for a license to operate a day care home to include a copy of a high school diploma or equivalent certificate with his or her application shall be deemed to be satisfied if the applicant includes a copy of a high school diploma or equivalent certificate or a copy of a degree from an accredited institution of higher education or vocational institution or equivalent certificate.

(Source: P.A. 99-143, eff. 7-27-15; 99-779, eff. 1-1-17;

100-201, eff. 8-18-17.)

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 105-5. 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 disbursed among 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, with the distribution of funding to be established by rule and with consideration to perinatal hospitals with safe birthing levels and quality metrics for healthy mothers and babies.

(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 Illinois Public Aid Code is amended by adding Section 14-14 as follows:

(305 ILCS 5/14-14 new)

Sec. 14-14. Increasing access to primary care in hospitals. The Department of Healthcare and Family Services shall develop a program to facilitate coordination between Federally Qualified Health Centers (FQHCs) and safety net hospitals, encourage coordination between Federally Qualified Health Centers (FQHCs) and 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. Coordination between FQHCs and safety hospitals may include, but is not limited to, embedding FQHC staff in hospitals, utilizing health information technology for care coordination and enabling FQHCs to connect hospital patients to community-based resources when needed to provide whole-person care. 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 FQHC care coordination services 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, if it is available, on the demographics and health status of the population, including data over time on health by gender identity, sexual orientation, race, ethnicity, age, socio-economic factors, geographic region, disability status, 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, provided that data exists to support such recommendations, regarding priorities and strategies for reducing and eliminating health disparities and health inequities in Illinois; including racial, ethnic, gender identification, sexual orientation, age, disability, 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 15 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 102nd 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 if departmental resources allow.

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 regularly evaluate and update the State Health Assessment and track implementation of the State Health Improvement Plan with revisions as necessary. 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 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 5.937 as follows:

(30 ILCS 105/5.937 new)

Sec. 5.937. The Sickle Cell Chronic Disease Fund.

Title VII. Hospital Closure

Article 135.

Section 135-5. The Illinois Health Facilities Planning Act is amended by changing Sections 4, 5.4, and 8.7 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. One member shall be a representative from the community with experience on the effects of discontinuing health care services or the closure of health care facilities on the surrounding community; provided, however, that all other members of the Board shall be appointed before this member shall be appointed. 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 6 ~~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) Six ~~Five~~ members of the State Board shall constitute a quorum. The affirmative vote of 6 ~~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 3960/5.4)

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

Sec. 5.4. Safety Net Impact Statement.

(a) General review criteria shall include a requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities licensed under the Nursing Home Care Act, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service.

(b) For the purposes of this Section, "safety net services" are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. Safety net service providers include, but are not limited to, hospitals and

private practice physicians that provide charity care, school-based health centers, migrant health clinics, rural health clinics, federally qualified health centers, community health centers, public health departments, and community mental health centers.

(c) As developed by the applicant, a Safety Net Impact Statement shall describe all of the following:

(1) The project's material impact, if any, on essential safety net services in the community, <u>including the impact on racial and health care disparities in the community,</u> to the extent that it is feasible for an applicant to have such knowledge.

(2) The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

(3) How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

(d) Safety Net Impact Statements shall also include all of the following:

(1) For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants

shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

(2) For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the State Board regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

(3) Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

(e) The Board staff shall publish a notice, that an application accompanied by a Safety Net Impact Statement has been filed, in a newspaper having general circulation within the area affected by the application. If no newspaper has a general circulation within the county, the Board shall post the notice in 5 conspicuous places within the proposed area.

(f) Any person, community organization, provider, or health system or other entity wishing to comment upon or oppose the application may file a Safety Net Impact Statement Response with the Board, which shall provide additional information concerning a project's impact on safety net services in the community.

(g) Applicants shall be provided an opportunity to submit a reply to any Safety Net Impact Statement Response.

(h) The State Board Staff Report shall include a statement as to whether a Safety Net Impact Statement was filed by the applicant and whether it included information on charity care, the amount of care provided to Medicaid patients, and information on teaching, research, or any other service provided by the applicant directly relevant to safety net services. The report shall also indicate the names of the parties submitting responses and the number of responses and replies, if any, that were filed.

(Source: P.A. 100-518, eff. 6-1-18.)

(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.

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)(1) 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.

(2) The Board may defer action on an application to discontinue a hospital that is pending before the Board as of the effective date of this amendatory Act of the 102nd General Assembly for up to 60 days after the effective date of this amendatory Act of the 102nd General Assembly.

(3) The Board may defer taking final action on an application to discontinue a hospital that is filed on or after January 12, 2021, until the earlier to occur of: (i) the expiration of the statewide disaster declaration proclaimed by the Governor of the State of Illinois due to the COVID-19 pandemic that is in effect on January 12, 2021, or any extension thereof, or July 1, 2021, whichever occurs later; or (ii) the expiration of the declaration of a public health emergency due to the COVID-19 pandemic as declared by the Secretary of the U.S. Department of Health and Human Services that is in effect on January 12, 2021, or any extension thereof, or July 1, 2021, whichever occurs later. This

paragraph (3) is repealed as of the date of the expiration of the statewide disaster declaration proclaimed by the Governor of the State of Illinois due to the COVID-19 pandemic that is in effect on January 12, 2021, or any extension thereof, or July 1, 2021, whichever occurs later.

(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 150.

Section 150-5. 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; and ~~.~~

(E) require MCOs to ensure that any Medicaid-certified provider under contract with an MCO and previously submitted on a roster on the date of service is paid for any medically necessary, Medicaid-covered, and authorized service rendered to any of the MCO's enrollees, regardless of inclusion on

the MCO's published and publicly available directory of available providers.

(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, 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 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.

(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 Department of Healthcare and Family Services, managed care organizations, a statewide organization representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by this

amendatory Act of the 102nd 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 102nd 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.)

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, appointed by the Governor.

(10) One member of a statewide association representing a majority of hospitals, appointed by the Governor.

(11) Two academic experts on Medicaid managed care programs, appointed by the Governor.

(12) One member of a statewide association representing primary care providers, appointed by the Governor.

(13) One member of a statewide association representing behavioral health providers, appointed by the Governor.

(14) Members representing Federally Qualified Health Centers, a long-term care association, a dental

association, pharmacies, pharmacists, a developmental disability association, a Medicaid consumer advocate, a Medicaid consumer, an association representing physicians, a behavioral health association, and an association representing pediatricians, appointed by the Governor.

(15) A member of a statewide association representing only safety-net hospitals, appointed by the Governor.

(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 102nd 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 processing to medical providers;

(7) review member access to health care services in the Medicaid Program, including specialty care services;

(8) review value-based and other alternative payment methodologies to make recommendations 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;

(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;

(11) review provider availability and make recommendations to increase providers where needed, including reviewing the regulatory environment and making recommendations for reforms;

(12) review capacity for culturally competent services, including translation services among providers; and

(13) review and recommend changes to the safety-net hospital definition to create different classifications of safety-net hospitals.

(f-5) The Department shall make available upon request the analytics of Medicaid managed care clearinghouse data regarding processing.

(g) 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 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, workforce development, and other services that support the Department's mission to promote health equity. Funds may not be used for any administrative costs of the Department.

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. Medicaid Business Opportunity Commission.

(a) The Medicaid Business Opportunity Commission is created within the Department of Healthcare and Family Services to develop a program to support and grow minority, women, and persons with disability owned businesses.

(b) The Commission shall consist of the following members:

(1) Two members appointed by the Illinois Legislative Black Caucus.

(2) Two members appointed by the Illinois Legislative Latino Caucus.

(3) Two members appointed by the Conference of Women Legislators of the Illinois General Assembly.

(4) Two members representing a statewide Medicaid health plan association, appointed by the Governor.

(5) One member representing the Department of Healthcare and Family Services, appointed by the Governor.

(6) Three members representing businesses currently registered with the Business Enterprise Program, appointed by the Governor.

(7) One member representing the disability community, appointed by the Governor.

(8) One member representing the Business Enterprise

Council, appointed by the Governor.

(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 members of the Commission shall designate co-chairs of the Commission to lead their efforts at the first meeting of the Commission.

(f) The Commission shall meet at least monthly beginning as soon as is practicable after the effective date of this amendatory Act of the 102nd General Assembly.

(g) The Commission shall:

(1) Develop a recommendation on a Medicaid Business Opportunity Program for Minority, Women, and Persons with Disability Owned business contracting requirements to be included in the contracts between the Department of Healthcare and Family Services and the Managed Care entities for the provision of Medicaid Services.

(2) Make recommendations on the process by which vendors or providers would be certified as eligible to be

included in the program and appropriate eligibility standards relative to the healthcare industry.

(3) Make a recommendation on whether to include not for profit organizations, diversity councils, or diversity chambers as eligible for certification.

(4) Make a recommendation on whether diverse staff shall be considered within the goals set for managed care entities.

(5) Make a recommendation on whether a new platform for certification is necessary to administer this program or if the existing platform for the Business Enterprise Program is capable of including recommended changes coming from this Commission.

(6) Make a recommendation on the ongoing activity of the Commission including structure, frequency of meetings, and agendas to ensure ongoing oversight of the program by the Commission.

(h) The Commission shall provide recommendations to the Department and the General assembly by April 15, 2021 in order to ensure prompt implementation of the Medicaid Business Opportunity Program.

(i) 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 172.

Section 172-5. The Illinois Public Aid Code is amended by changing Section 14-13 as follows:

(305 ILCS 5/14-13)

Sec. 14-13. Reimbursement for inpatient stays extended beyond medical necessity.

(a) By October 1, 2019, the Department shall by rule implement a methodology effective for dates of service July 1, 2019 and later to reimburse hospitals for inpatient stays extended beyond medical necessity due to the inability of the Department or the managed care organization in which a recipient is enrolled or the hospital discharge planner to find an appropriate placement after discharge from the hospital. The Department shall evaluate the effectiveness of the current reimbursement rate for inpatient hospital stays beyond medical necessity.

(b) The methodology shall provide reasonable compensation for the services provided attributable to the days of the extended stay for which the prevailing rate methodology provides no reimbursement. The Department may use a day outlier program to satisfy this requirement. The reimbursement

rate shall be set at a level so as not to act as an incentive to avoid transfer to the appropriate level of care needed or placement, after discharge.

(c) The Department shall require managed care organizations to adopt this methodology or an alternative methodology that pays at least as much as the Department's adopted methodology unless otherwise mutually agreed upon contractual language is developed by the provider and the managed care organization for a risk-based or innovative payment methodology.

(d) Days beyond medical necessity shall not be eligible for per diem add-on payments under the Medicaid High Volume Adjustment (MHVA) or the Medicaid Percentage Adjustment (MPA) programs.

(e) For services covered by the fee-for-service program, reimbursement under this Section shall only be made for days beyond medical necessity that occur after the hospital has notified the Department of the need for post-discharge placement. For services covered by a managed care organization, hospitals shall notify the appropriate managed care organization of an admission within 24 hours of admission. For every 24-hour period beyond the initial 24 hours after admission that the hospital fails to notify the managed care organization of the admission, reimbursement under this subsection shall be reduced by one day.

(Source: P.A. 101-209, eff. 8-5-19.)

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, subject to appropriation, 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.Medicaid Managed Care Reform

Article 185.

Section 185-1. Short title. This Article may be cited as the Medicaid Technical Assistance Act. References in this Article to "this Act" mean this Article.

Section 185-5. Definitions. As used in this Act:

"Behavioral health providers" means mental health and substance use disorder providers.

"Department" means the Department of Healthcare and Family Services.

"Health care providers" means organizations who provide physical, mental, substance use disorder, or social determinant of health services.

"Network adequacy" means a Medicaid beneficiaries' ability to access all necessary provider types within time and distance standards as defined in the Managed Care Organization model contract.

"Service deserts" means geographic areas of the State with no or limited Medicaid providers that accept Medicaid.

"Social determinants of health" means any conditions that impact an individual's health, including, but not limited to, access to healthy food, safety, education, and housing stability.

"Stakeholders" means, but are not limited to, health care providers, advocacy organizations, managed care organizations, Medicaid beneficiaries, and State and city partners.

Section 185-10. Medicaid Technical Assistance Center. The Department of Healthcare and Family Services shall establish a Medicaid Technical Assistance Center. The Medicaid Technical Assistance Center shall operate as a cross-system educational resource to strengthen the business infrastructure of health care provider organizations in Illinois to ultimately increase the capacity, access, and quality of Illinois' Medicaid managed care program, HealthChoice Illinois. The Medicaid Technical Assistance Center shall be established within the

Department's Office of Medicaid Innovation.

Section 185-15. Collaboration. The Medicaid Technical Assistance Center shall collaborate with public and private partners throughout the State to identify, establish, and maintain best practices necessary for health providers to ensure their capacity to participate in HealthChoice Illinois. The Medicaid Technical Assistance Center shall administer the following:

(1) Trainings: The Medicaid Technical Assistance Center shall create and administer ongoing trainings for health care providers. Trainings may be subcontracted. The Medicaid Technical Assistance Center shall provide in-person and web-based trainings. In-person training shall be conducted throughout the State. All trainings must be free of charge. The Medicaid Technical Assistance Center shall administer post-training surveys and incorporate feedback. Training content and delivery must be reflective of Illinois providers' varying levels of readiness, resources, and client populations.

(2) Web-based resources: The Medicaid Technical Assistance Center shall maintain an independent, easy to navigate, and up-to-date website that includes, but is not limited to: recorded training archives, a training calendar, provider resources and tools, up-to-date explanations of Department and managed care organization

guidance, a running database of frequently asked questions and contact information for key staff members of the Department, managed care organizations, and the Medicaid Technical Assistance Center.

(3) Learning collaboratives: The Medicaid Technical Assistance Center shall host regional learning collaboratives that will supplement the Medicaid Technical Assistance Center training curriculum to bring together groups of stakeholders to share issues, best practices, and escalate issues. Leadership of the Department and managed care organizations shall attend learning collaboratives on a quarterly basis.

(4) Network adequacy reports: The Medicaid Technical Assistance Center shall publicly release a report on Medicaid provider network adequacy within the first 3 years of implementation and annually thereafter. The reports shall identify provider service deserts and health care disparities by race and ethnicity.

Section 185-20. Federal financial participation. The Department of Healthcare and Family Services, to the extent allowable under federal law, shall maximize federal financial participation for any moneys appropriated to the Department for the Medicaid Technical Assistance Center. Any federal financial participation funds obtained in accordance with this Section shall be used for the further development and

expansion of the Medicaid Technical Assistance Center. All federal financial participation funds obtained under this subsection shall be deposited into the Medicaid Technical Assistance Center Fund created under Section 185-25.

Section 185-25. Medicaid Technical Assistance Center Fund. The Medicaid Technical Assistance Center Fund is created as a special fund in the State treasury. The Fund shall consist of any moneys appropriated to the Department of Healthcare and Family Services for the purposes of this Act and any federal financial participation funds obtained as provided under Section 20. Moneys in the Fund shall be used for carrying out the purposes of this Act and for no other purpose. All interest earned on the moneys in the Fund shall be deposited into the Fund.

Section 185-90. The State Finance Act is amended by adding Section 5.936 as follows:

(30 ILCS 105/5.936 new)

Sec. 5.936. The Medicaid Technical Assistance Center Fund.

Title XI.Miscellaneous

Article 999.

Section 999-99. Effective date. This Act takes effect upon becoming law.".