AN ACT concerning regulation.

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

Article 1.

Section 1-5. The Illinois Public Aid Code is amended by adding Section 5A-2.1 as follows:

(305 ILCS 5/5A-2.1 new)

Sec. 5A-2.1. Continuation of Section 5A-2 of this Code; validation.

(a) The General Assembly finds and declares that:

(1) Public Act 101-650, which took effect on July 7, 2020, contained provisions that would have changed the repeal date for Section 5A-2 of this Act from July 1, 2020 to December 31, 2022.

(2) The Statute on Statutes sets forth general rules on the repeal of statutes and the construction of multiple amendments, but Section 1 of that Act also states that these rules will not be observed when the result would be "inconsistent with the manifest intent of the General Assembly or repugnant to the context of the statute".

(3) This amendatory Act of the 101st General Assembly manifests the intention of the General Assembly to extend

the repeal date for Section 5A-2 of this Code and have Section 5A-2 of this Code, as amended by Public Act 101-650, continue in effect until December 31, 2022.

(b) Any construction of this Code that results in the repeal of Section 5A-2 of this Code on July 1, 2020 would be inconsistent with the manifest intent of the General Assembly and repugnant to the context of this Code.

(c) It is hereby declared to have been the intent of the General Assembly that Section 5A-2 of this Code shall not be subject to repeal on July 1, 2020.

(d) Section 5A-2 of this Code shall be deemed to have been in continuous effect since July 8, 1992 (the effective date of Public Act 87-861), and it shall continue to be in effect, as amended by Public Act 101-650, until it is otherwise lawfully amended or repealed. All previously enacted amendments to the Section taking effect on or after July 8, 1992, are hereby validated.

(e) In order to ensure the continuing effectiveness of Section 5A-2 of this Code, that Section is set forth in full and reenacted by this amendatory Act of the 101st General Assembly. In this amendatory Act of the 101st General Assembly, the base text of the reenacted Section is set forth as amended by Public Act 101-650.

(f) All actions of the Illinois Department or any other person or entity taken in reliance on or pursuant to Section 5A-2 of this Code are hereby validated.

Section 1-10. The Illinois Public Aid Code is amended by reenacting Section 5A-2 as follows:

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

Sec. 5A-2. Assessment.

(a)(1) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018, or as long as continued under Section 5A-16, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period of April through June 2015, the amount of $218.38 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $20,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, or as provided in Section 5A-16, in addition

to any federally required State share as authorized under paragraph (1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For State fiscal years 2009 through 2018, or as provided in Section 5A-16, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $197.19 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2019 and 2020, a hospital's occupied bed

days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10, for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $221.50 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided however: for the period of July 1, 2020 through December 31, 2020, (i) the assessment shall be equal to 50% of the annual amount; and

(ii) the amount of $221.50 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology for fiscal years 2021 through December 31, 2022 not be approved on or before June 30, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the assessment methodology for July 1, 2020 through December 31, 2022, is approved on or after July 1, 2020, it shall be retroactive to July 1, 2020, subject to federal approval and provided that the payments authorized under Section 5A-12.7

have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph.

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, or as provided in Section 5A-16, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator

of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, in addition to any federally required State share as authorized under paragraph (1), the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, or as provided in Section 5A-16, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross

revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01358 multiplied by the hospital's outpatient gross revenue. For State fiscal years 2019 and 2020, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10, for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01525 multiplied by the hospital's outpatient gross revenue, provided however: (i) for the period of July 1, 2020 through December 31, 2020, the assessment shall be equal to 50% of the annual amount; and (ii) the amount of .01525 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's outpatient revenue data from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology above for fiscal years 2021 through

calendar year 2022 not be approved prior to July 1, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the change in the assessment methodology above for July 1, 2020 through December 31, 2022, is approved after June 30, 2020, it shall have a retroactive effective date of July 1, 2020, subject to federal approval and provided that the payments authorized under Section 12A-7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph.

(b-6)(1) As used in this Section, "ACA Assessment Adjustment" means:

(A) For the period of July 1, 2016 through December 31, 2016, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the

month of April 2016 multiplied by 6.

(B) For the period of January 1, 2017 through June 30, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2016 multiplied by 6, except that the amount calculated under this subparagraph (B) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning July 1, 2016 through December 31, 2016 and the estimated payments due and payable in the month of April 2016 multiplied by 6 as described in subparagraph (A).

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2017 multiplied by 6, except that the amount calculated under this subparagraph (C) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning January 1, 2017

through June 30, 2017 and the estimated payments due and payable in the month of October 2016 multiplied by 6 as described in subparagraph (B).

(D) For the period of January 1, 2018 through June 30, 2018, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2017 multiplied by 6, except that:

(i) the amount calculated under this subparagraph (D) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period of July 1, 2017 through December 31, 2017 and the estimated payments due and payable in the month of April 2017 multiplied by 6 as described in subparagraph (C); and

(ii) the amount calculated under this subparagraph (D) shall be adjusted to include the product of .19125 multiplied by the sum of the fee-for-service payments, if any, estimated to be paid to hospitals under subsection (b) of Section 5A-12.5.

(2) The Department shall complete and apply a final reconciliation of the ACA Assessment Adjustment prior to June 30, 2018 to account for:

(A) any differences between the actual payments issued or scheduled to be issued prior to June 30, 2018 as authorized in Section 5A-12.5 for the period of January 1, 2018 through June 30, 2018 and the estimated payments due and payable in the month of October 2017 multiplied by 6 as described in subparagraph (D); and

(B) any difference between the estimated fee-for-service payments under subsection (b) of Section 5A-12.5 and the amount of such payments that are actually scheduled to be paid.

The Department shall notify hospitals of any additional amounts owed or reduction credits to be applied to the June 2018 ACA Assessment Adjustment. This is to be considered the final reconciliation for the ACA Assessment Adjustment.

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph (D) of paragraph (1) and pursuant to paragraph (2), attributable to the scheduled payments authorized under subsection (b) of Section 5A-12.5 that are not issued in full by the final day of the period attributable to each payment authorized under subsection (b) of Section 5A-12.5, shall be refunded.

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be

limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than $450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(b-7)(1) As used in this Section, "Assessment Adjustment" means:

(A) For the period of July 1, 2020 through December 31, 2020, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(B) For each calendar quarter beginning on and after January 1, 2021, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(2) The Department shall calculate and notify each hospital of the total Assessment Adjustment and any additional assessment owed by the hospital or refund owed to the hospital on either a semi-annual or annual basis. Such notice shall be

issued at least 30 days prior to any period in which the assessment will be adjusted. Any additional assessment owed by the hospital or refund owed to the hospital shall be uniformly applied to the assessment owed by the hospital in monthly installments for the subsequent semi-annual period or calendar year. If no assessment is owed in the subsequent year, any amount owed by the hospital or refund due to the hospital, shall be paid in a lump sum.

(3) The Department shall publish all details of the Assessment Adjustment calculation performed each year on its website within 30 days of completing the calculation, and also submit the details of the Assessment Adjustment calculation as part of the Department's annual report to the General Assembly.

(c) (Blank).

(d) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section, as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act.

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by

federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 100-581, eff. 3-12-18; 101-10, eff. 6-5-19; 101-650, eff. 7-7-20.)

Article 5.

Section 5-5. The Illinois Public Aid Code is amended by changing Sections 5-5.07, 5-5e.1, and 14-12 as follows:

(305 ILCS 5/5-5.07)

Sec. 5-5.07. Inpatient psychiatric stay; DCFS per diem rate. The Department of Children and Family Services shall pay the DCFS per diem rate for inpatient psychiatric stay at a free-standing psychiatric hospital effective the 11th day when a child is in the hospital beyond medical necessity, and the parent or caregiver has denied the child access to the home and has refused or failed to make provisions for another living arrangement for the child or the child's discharge is being delayed due to a pending inquiry or investigation by the Department of Children and Family Services. If any portion of a hospital stay is reimbursed under this Section, the hospital stay shall not be eligible for payment under the provisions of Section 14-13 of this Code. This Section is inoperative on and after July 1, 2021 ~~2020~~ ~~2019~~. Notwithstanding the provision of Public Act 101-209 stating that this Section is inoperative on and after July 1, 2020, this Section is operative from July 1, 2020 through June 30, 2021.

(Source: P.A. 100-646, eff. 7-27-18; reenacted by 101-15, eff. 6-14-19; reenacted by 101-209, eff. 8-5-19; revised 9-24-19.)

Article 10.

Section 10-5. The Illinois Public Aid Code is amended by changing Section 14-12 as follows:

(305 ILCS 5/14-12)

Sec. 14-12. Hospital rate reform payment system. The hospital payment system pursuant to Section 14-11 of this Article shall be as follows:

(a) Inpatient hospital services. Effective for discharges on and after July 1, 2014, reimbursement for inpatient general acute care services shall utilize the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, version 30, distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. Initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 30.0 adjusted for the Illinois experience.

(2) The Department shall establish a statewide-standardized amount to be used in the inpatient reimbursement system. The Department shall publish these amounts on its website no later than 10 calendar days prior to their effective date.

(3) In addition to the statewide-standardized amount, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid providers or services for trauma, transplantation services, perinatal care, and Graduate Medical Education (GME).

(4) The Department shall develop add-on payments to

account for exceptionally costly inpatient stays, consistent with Medicare outlier principles. Outlier fixed loss thresholds may be updated to control for excessive growth in outlier payments no more frequently than on an annual basis, but at least triennially. Upon updating the fixed loss thresholds, the Department shall be required to update base rates within 12 months.

(5) The Department shall define those hospitals or distinct parts of hospitals that shall be exempt from the APR-DRG reimbursement system established under this Section. The Department shall publish these hospitals' inpatient rates on its website no later than 10 calendar days prior to their effective date.

(6) Beginning July 1, 2014 and ending on June 30, 2024, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for safety-net hospitals defined in Section 5-5e.1 of this Code excluding pediatric hospitals.

(7) Beginning July 1, 2014, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for Illinois freestanding inpatient psychiatric hospitals that are not designated as children's hospitals by the Department but are primarily treating patients under the age of 21.

(7.5) (Blank).

(8) Beginning July 1, 2018, in addition to the statewide-standardized amount, the Department shall adjust the rate of reimbursement for hospitals designated by the Department of Public Health as a Perinatal Level II or II+ center by applying the same adjustor that is applied to Perinatal and Obstetrical care cases for Perinatal Level III centers, as of December 31, 2017.

(9) Beginning July 1, 2018, in addition to the statewide-standardized amount, the Department shall apply the same adjustor that is applied to trauma cases as of December 31, 2017 to inpatient claims to treat patients with burns, including, but not limited to, APR-DRGs 841, 842, 843, and 844.

(10) Beginning July 1, 2018, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%.

(11) Beginning July 1, 2018, the reimbursement for inpatient rehabilitation services shall be increased by the addition of a $96 per day add-on.

(b) Outpatient hospital services. Effective for dates of service on and after July 1, 2014, reimbursement for outpatient

services shall utilize the Enhanced Ambulatory Procedure Grouping (EAPG) software, version 3.7 distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. The initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 3.7.

(2) The Department shall establish service specific statewide-standardized amounts to be used in the reimbursement system.

(A) The initial statewide standardized amounts, with the labor portion adjusted by the Calendar Year 2013 Medicare Outpatient Prospective Payment System wage index with reclassifications, shall be published by the Department on its website no later than 10 calendar days prior to their effective date.

(B) The Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F. For outpatient services provided on or before June 30, 2018, the EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments under Section 5A-12.4 of

this Code net of the associated tax costs are equal to the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid hospital outpatient providers or services, including outpatient high volume or safety-net hospitals. Beginning July 1, 2018, the outpatient high volume adjustor shall be increased to increase annual expenditures associated with this adjustor by $79,200,000, based on the State Fiscal Year 2015 base year data and this adjustor shall apply to public hospitals, except for large public hospitals, as defined under 89 Ill. Adm. Code 148.25(a).

(4) Beginning July 1, 2018, in addition to the statewide standardized amounts, the Department shall make an add-on payment for outpatient expensive devices and drugs. This add-on payment shall at least apply to claim lines that: (i) are assigned with one of the following EAPGs: 490, 1001 to 1020, and coded with one of the following revenue codes: 0274 to 0276, 0278; or (ii) are assigned with one of the following EAPGs: 430 to 441, 443, 444, 460 to 465, 495, 496, 1090. The add-on payment shall be calculated as follows: the claim line's covered charges multiplied by the hospital's total acute cost to charge ratio, less the claim line's EAPG payment plus $1,000,

multiplied by 0.8.

(5) Beginning July 1, 2018, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%.

(6) Effective for dates of service on or after July 1, 2018, the Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F, such that each Critical Access Hospital's standardized amount for outpatient services shall be increased by the applicable uniform percentage determined pursuant to paragraph (5) of this subsection. It is the intent of the General Assembly that the adjustments required under this paragraph (6) by Public Act 100-1181 shall be applied retroactively to claims for dates of service provided on or after July 1, 2018.

(7) Effective for dates of service on or after March 8, 2019 (the effective date of Public Act 100-1181), the Department shall recalculate and implement an updated statewide-standardized amount for outpatient services

provided by hospitals that are not Critical Access Hospitals to reflect the applicable uniform percentage determined pursuant to paragraph (5).

(1) Any recalculation to the statewide-standardized amounts for outpatient services provided by hospitals that are not Critical Access Hospitals shall be the amount necessary to achieve the increase in the statewide-standardized amounts for outpatient services increased by a uniform percentage, so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection, for all hospitals that are not Critical Access Hospitals, multiplied by 46%.

(2) It is the intent of the General Assembly that the recalculations required under this paragraph (7) by Public Act 100-1181 shall be applied prospectively to claims for dates of service provided on or after March 8, 2019 (the effective date of Public Act 100-1181) and that no recoupment or repayment by the Department or an MCO of payments attributable to recalculation under this paragraph (7), issued to the hospital for dates of service on or after July 1, 2018 and before March 8, 2019 (the effective date of Public

Act 100-1181), shall be permitted.

(8) The Department shall ensure that all necessary adjustments to the managed care organization capitation base rates necessitated by the adjustments under subparagraph (6) or (7) of this subsection are completed and applied retroactively in accordance with Section 5-30.8 of this Code within 90 days of March 8, 2019 (the effective date of Public Act 100-1181).

(9) Within 60 days after federal approval of the change made to the assessment in Section 5A-2 by this amendatory Act of the 101st General Assembly, the Department shall incorporate into the EAPG system for outpatient services those services performed by hospitals currently billed through the Non-Institutional Provider billing system.

(c) In consultation with the hospital community, the Department is authorized to replace 89 Ill. Admin. Code 152.150 as published in 38 Ill. Reg. 4980 through 4986 within 12 months of June 16, 2014 (the effective date of Public Act 98-651). If the Department does not replace these rules within 12 months of June 16, 2014 (the effective date of Public Act 98-651), the rules in effect for 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall remain in effect until modified by rule by the Department. Nothing in this subsection shall be construed to mandate that the Department file a replacement rule.

(d) Transition period. There shall be a transition period to the reimbursement systems authorized under this Section that

shall begin on the effective date of these systems and continue until June 30, 2018, unless extended by rule by the Department. To help provide an orderly and predictable transition to the new reimbursement systems and to preserve and enhance access to the hospital services during this transition, the Department shall allocate a transitional hospital access pool of at least $290,000,000 annually so that transitional hospital access payments are made to hospitals.

(1) After the transition period, the Department may begin incorporating the transitional hospital access pool into the base rate structure; however, the transitional hospital access payments in effect on June 30, 2018 shall continue to be paid, if continued under Section 5A-16.

(2) After the transition period, if the Department reduces payments from the transitional hospital access pool, it shall increase base rates, develop new adjustors, adjust current adjustors, develop new hospital access payments based on updated information, or any combination thereof by an amount equal to the decreases proposed in the transitional hospital access pool payments, ensuring that the entire transitional hospital access pool amount shall continue to be used for hospital payments.

(d-5) Hospital and health care transformation program. The Department shall develop a hospital and health care transformation program to provide financial assistance to hospitals in transforming their services and care models to

better align with the needs of the communities they serve. The payments authorized in this Section shall be subject to approval by the federal government.

(1) Phase 1. In State fiscal years 2019 through 2020, the Department shall allocate funds from the transitional access hospital pool to create a hospital transformation pool of at least $262,906,870 annually and make hospital transformation payments to hospitals. Subject to Section 5A-16, in State fiscal years 2019 and 2020, an Illinois hospital that received either a transitional hospital access payment under subsection (d) or a supplemental payment under subsection (f) of this Section in State fiscal year 2018, shall receive a hospital transformation payment as follows:

(A) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is equal to or greater than 45%, the hospital transformation payment shall be equal to 100% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(B) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is equal to or greater than 25% but less than 45%, the hospital transformation payment shall be equal to 75% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized

under subsection (f).

(C) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is less than 25%, the hospital transformation payment shall be equal to 50% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(2) Phase 2.

(A) The funding amount from phase one shall be incorporated into directed payment and pass-through payment methodologies described in Section 5A-12.7.

(B) Because there are communities in Illinois that experience significant health care disparities due to systemic racism, as recently emphasized by the COVID-19 pandemic, aggravated by social determinants of health and a lack of sufficiently allocated healthcare resources, particularly community-based services, preventive care, obstetric care, chronic disease management, and specialty care, the Department shall establish a health care transformation program that shall be supported by the transformation funding pool. It is the intention of the General Assembly that innovative partnerships funded by the pool must be designed to establish or improve integrated health care delivery systems that will provide significant access to the Medicaid and uninsured populations in

their communities, as well as improve health care equity. It is also the intention of the General Assembly that partnerships recognize and address the disparities revealed by the COVID-19 pandemic, as well as the need for post-COVID care. During State fiscal years 2021 through 2027, the hospital and health care transformation program shall be supported by an annual transformation funding pool of up to $150,000,000, pending federal matching funds, to be allocated during the specified fiscal years for the purpose of facilitating hospital and health care transformation. No disbursement of moneys for transformation projects from the transformation funding pool described under this Section shall be considered an award, a grant, or an expenditure of grant funds. Funding agreements made in accordance with the transformation program shall be considered purchases of care under the Illinois Procurement Code, and funds shall be expended by the Department in a manner that maximizes federal funding to expend the entire allocated amount.

The Department shall convene, within 30 days after the effective date of this amendatory Act of the 101st General Assembly, a workgroup that includes subject matter experts on healthcare disparities and stakeholders from distressed communities, which could be a subcommittee of the Medicaid Advisory Committee,

to review and provide recommendations on how Department policy, including health care transformation, can improve health disparities and the impact on communities disproportionately affected by COVID-19. The workgroup shall consider and make recommendations on the following issues: a community safety-net designation of certain hospitals, racial equity, and a regional partnership to bring additional specialty services to communities. ~~Whereas there are communities in Illinois that suffer from significant health care disparities aggravated by social determinants of health and a lack of sufficiently allocated healthcare resources, particularly community-based services and preventive care, there is established a new hospital and health care transformation program, which shall be supported by a transformation funding pool. An application for funding from the hospital and health care transformation program may incorporate the campus of a hospital closed after January 1, 2018 or a hospital that has provided notice of its intent to close pursuant to Section 8.7 of the Illinois Health Facilities Planning Act. During State Fiscal Years 2021 through 2023, the hospital and health care transformation program shall be supported by an annual transformation funding pool of at least $150,000,000~~

~~to be allocated during the specified fiscal years for the purpose of facilitating hospital and health care transformation. The Department shall not allocate funds associated with the hospital and health care transformation pool as established in this subparagraph until the General Assembly has established in law or resolution, further criteria for dispersal or allocation of those funds after the effective date of this amendatory Act of 101st General Assembly.~~

(C) As provided in paragraph (9) of Section 3 of the Illinois Health Facilities Planning Act, any hospital participating in the transformation program may be excluded from the requirements of the Illinois Health Facilities Planning Act for those projects related to the hospital's transformation. To be eligible, the hospital must submit to the Health Facilities and Services Review Board approval from the Department that the project is a part of the hospital's transformation.

(D) As provided in subsection (a-20) of Section 32.5 of the Emergency Medical Services (EMS) Systems Act, a hospital that received hospital transformation payments under this Section may convert to a freestanding emergency center. To be eligible for such a conversion, the hospital must submit to the

Department of Public Health approval from the Department that the project is a part of the hospital's transformation.

(E) Criteria for proposals. To be eligible for funding under this Section, a transformation proposal shall meet all of the following criteria:

(i) the proposal shall be designed based on community needs assessment completed by either a University partner or other qualified entity with significant community input;

(ii) the proposal shall be a collaboration among providers across the care and community spectrum, including preventative care, primary care specialty care, hospital services, mental health and substance abuse services, as well as community-based entities that address the social determinants of health;

(iii) the proposal shall be specifically designed to improve healthcare outcomes and reduce healthcare disparities, and improve the coordination, effectiveness, and efficiency of care delivery;

(iv) the proposal shall have specific measurable metrics related to disparities that will be tracked by the Department and made public by the Department;

(v) the proposal shall include a commitment to include Business Enterprise Program certified vendors or other entities controlled and managed by minorities or women; and

(vi) the proposal shall specifically increase access to primary, preventive, or specialty care.

(F) Entities eligible to be funded.

(i) Proposals for funding should come from collaborations operating in one of the most distressed communities in Illinois as determined by the U.S. Centers for Disease Control and Prevention's Social Vulnerability Index for Illinois and areas disproportionately impacted by COVID-19 or from rural areas of Illinois.

(ii) The Department shall prioritize partnerships from distressed communities, which include Business Enterprise Program certified vendors or other entities controlled and managed by minorities or women and also include one or more of the following: safety-net hospitals, critical access hospitals, the campuses of hospitals that have closed since January 1, 2018, or other healthcare providers designed to address specific healthcare disparities, including the impact of COVID-19 on individuals and the community and the need for post-COVID care. All funded proposals

must include specific measurable goals and metrics related to improved outcomes and reduced disparities which shall be tracked by the Department.

(iii) The Department should target the funding in the following ways: $30,000,000 of transformation funds to projects that are a collaboration between a safety-net hospital, particularly community safety-net hospitals, and other providers and designed to address specific healthcare disparities, $20,000,000 of transformation funds to collaborations between safety-net hospitals and a larger hospital partner that increases specialty care in distressed communities, $30,000,000 of transformation funds to projects that are a collaboration between hospitals and other providers in distressed areas of the State designed to address specific healthcare disparities, $15,000,000 to collaborations between critical access hospitals and other providers designed to address specific healthcare disparities, and $15,000,000 to cross-provider collaborations designed to address specific healthcare disparities, and $5,000,000 to collaborations that focus on workforce development.

(iv) The Department may allocate up to $5,000,000 for planning, racial equity analysis, or consulting resources for the Department or entities without the resources to develop a plan to meet the criteria of this Section. Any contract for consulting services issued by the Department under this subparagraph shall comply with the provisions of Section 5-45 of the State Officials and Employees Ethics Act. Based on availability of federal funding, the Department may directly procure consulting services or provide funding to the collaboration. The provision of resources under this subparagraph is not a guarantee that a project will be approved.

(v) The Department shall take steps to ensure that safety-net hospitals operating in under-resourced communities receive priority access to hospital and healthcare transformation funds, including consulting funds, as provided under this Section.

(G) Process for submitting and approving projects for distressed communities. The Department shall issue a template for application. The Department shall post any proposal received on the Department's website for at least 2 weeks for public comment, and any such public comment shall also be considered in the review

process. Applicants may request that proprietary financial information be redacted from publicly posted proposals and the Department in its discretion may agree. Proposals for each distressed community must include all of the following:

(i) A detailed description of how the project intends to affect the goals outlined in this subsection, describing new interventions, new technology, new structures, and other changes to the healthcare delivery system planned.

(ii) A detailed description of the racial and ethnic makeup of the entities' board and leadership positions and the salaries of the executive staff of entities in the partnership that is seeking to obtain funding under this Section.

(iii) A complete budget, including an overall timeline and a detailed pathway to sustainability within a 5-year period, specifying other sources of funding, such as in-kind, cost-sharing, or private donations, particularly for capital needs. There is an expectation that parties to the transformation project dedicate resources to the extent they are able and that these expectations are delineated separately for each entity in the proposal.

(iv) A description of any new entities formed or other legal relationships between collaborating entities and how funds will be allocated among participants.

(v) A timeline showing the evolution of sites and specific services of the project over a 5-year period, including services available to the community by site.

(vi) Clear milestones indicating progress toward the proposed goals of the proposal as checkpoints along the way to continue receiving funding. The Department is authorized to refine these milestones in agreements, and is authorized to impose reasonable penalties, including repayment of funds, for substantial lack of progress.

(vii) A clear statement of the level of commitment the project will include for minorities and women in contracting opportunities, including as equity partners where applicable, or as subcontractors and suppliers in all phases of the project.

(viii) If the community study utilized is not the study commissioned and published by the Department, the applicant must define the methodology used, including documentation of clear

community participation.

(ix) A description of the process used in collaborating with all levels of government in the community served in the development of the project, including, but not limited to, legislators and officials of other units of local government.

(x) Documentation of a community input process in the community served, including links to proposal materials on public websites.

(xi) Verifiable project milestones and quality metrics that will be impacted by transformation. These project milestones and quality metrics must be identified with improvement targets that must be met.

(xii) Data on the number of existing employees by various job categories and wage levels by the zip code of the employees' residence and benchmarks for the continued maintenance and improvement of these levels. The proposal must also describe any retraining or other workforce development planned for the new project.

(xiii) If a new entity is created by the project, a description of how the board will be reflective of the community served by the proposal.

(xiv) An explanation of how the proposal will address the existing disparities that exacerbated the impact of COVID-19 and the need for post-COVID care in the community, if applicable.

(xv) An explanation of how the proposal is designed to increase access to care, including specialty care based upon the community's needs.

(H) The Department shall evaluate proposals for compliance with the criteria listed under subparagraph (G). Proposals meeting all of the criteria may be eligible for funding with the areas of focus prioritized as described in item (ii) of subparagraph (F). Based on the funds available, the Department may negotiate funding agreements with approved applicants to maximize federal funding. Nothing in this subsection requires that an approved project be funded to the level requested. Agreements shall specify the amount of funding anticipated annually, the methodology of payments, the limit on the number of years such funding may be provided, and the milestones and quality metrics that must be met by the projects in order to continue to receive funding during each year of the program. Agreements shall specify the terms and conditions under which a health care facility that receives funds under a purchase of care agreement and closes in violation of the terms of the agreement must

pay an early closure fee no greater than 50% of the funds it received under the agreement, prior to the Health Facilities and Services Review Board considering an application for closure of the facility. Any project that is funded shall be required to provide quarterly written progress reports, in a form prescribed by the Department, and at a minimum shall include the progress made in achieving any milestones or metrics or Business Enterprise Program commitments in its plan. The Department may reduce or end payments, as set forth in transformation plans, if milestones or metrics or Business Enterprise Program commitments are not achieved. The Department shall seek to make payments from the transformation fund in a manner that is eligible for federal matching funds.

In reviewing the proposals, the Department shall take into account the needs of the community, data from the study commissioned by the Department from the University of Illinois-Chicago if applicable, feedback from public comment on the Department's website, as well as how the proposal meets the criteria listed under subparagraph (G). Alignment with the Department's overall strategic initiatives shall be an important factor. To the extent that fiscal year funding is not adequate to fund all eligible projects that apply, the Department shall prioritize

applications that most comprehensively and effectively address the criteria listed under subparagraph (G).

(3) (Blank).

(4) Hospital Transformation Review Committee. There is created the Hospital Transformation Review Committee. The Committee shall consist of 14 members. No later than 30 days after March 12, 2018 (the effective date of Public Act 100-581), the 4 legislative leaders shall each appoint 3 members; the Governor shall appoint the Director of Healthcare and Family Services, or his or her designee, as a member; and the Director of Healthcare and Family Services shall appoint one member. Any vacancy shall be filled by the applicable appointing authority within 15 calendar days. The members of the Committee shall select a Chair and a Vice-Chair from among its members, provided that the Chair and Vice-Chair cannot be appointed by the same appointing authority and must be from different political parties. The Chair shall have the authority to establish a meeting schedule and convene meetings of the Committee, and the Vice-Chair shall have the authority to convene meetings in the absence of the Chair. The Committee may establish its own rules with respect to meeting schedule, notice of meetings, and the disclosure of documents; however, the Committee shall not have the power to subpoena individuals or documents and any rules must be approved by 9 of the 14 members. The Committee shall

perform the functions described in this Section and advise and consult with the Director in the administration of this Section. In addition to reviewing and approving the policies, procedures, and rules for the hospital and health care transformation program, the Committee shall consider and make recommendations related to qualifying criteria and payment methodologies related to safety-net hospitals and children's hospitals. Members of the Committee appointed by the legislative leaders shall be subject to the jurisdiction of the Legislative Ethics Commission, not the Executive Ethics Commission, and all requests under the Freedom of Information Act shall be directed to the applicable Freedom of Information officer for the General Assembly. The Department shall provide operational support to the Committee as necessary. The Committee is dissolved on April 1, 2019.

(e) Beginning 36 months after initial implementation, the Department shall update the reimbursement components in subsections (a) and (b), including standardized amounts and weighting factors, and at least triennially and no more frequently than annually thereafter. The Department shall publish these updates on its website no later than 30 calendar days prior to their effective date.

(f) Continuation of supplemental payments. Any supplemental payments authorized under Illinois Administrative Code 148 effective January 1, 2014 and that continue during the

period of July 1, 2014 through December 31, 2014 shall remain in effect as long as the assessment imposed by Section 5A-2 that is in effect on December 31, 2017 remains in effect.

(g) Notwithstanding subsections (a) through (f) of this Section and notwithstanding the changes authorized under Section 5-5b.1, any updates to the system shall not result in any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors, including, but not limited to, the number of individuals in the medical assistance program and the severity of illness of the individuals.

(h) The Department shall have the authority to modify by rulemaking any changes to the rates or methodologies in this Section as required by the federal government to obtain federal financial participation for expenditures made under this Section.

(i) Except for subsections (g) and (h) of this Section, the Department shall, pursuant to subsection (c) of Section 5-40 of the Illinois Administrative Procedure Act, provide for

presentation at the June 2014 hearing of the Joint Committee on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559 (Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977 (Hospital Reimbursement Changes), and published in the Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

(j) Out-of-state hospitals. Beginning July 1, 2018, for purposes of determining for State fiscal years 2019 and 2020 and subsequent fiscal years the hospitals eligible for the payments authorized under subsections (a) and (b) of this Section, the Department shall include out-of-state hospitals that are designated a Level I pediatric trauma center or a Level I trauma center by the Department of Public Health as of December 1, 2017.

(k) The Department shall notify each hospital and managed care organization, in writing, of the impact of the updates under this Section at least 30 calendar days prior to their effective date.

(Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19; 101-81, eff. 7-12-19; 101-650, eff. 7-7-20.)

Article 13.

Section 13-5. The Illinois Public Aid Code is amended by changing Section 12-4.53 as follows:

(305 ILCS 5/12-4.53)

Sec. 12-4.53. Prospective Payment System (PPS) rates. Effective January 1, 2021, and subsequent years, based on specific appropriation, the Prospective Payment System (PPS) rates for FQHCs shall be increased based on the cost principles found at 45 Code of Federal Regulations Part 75 or its successor. Such rates shall be increased by using any of the following methods: reducing the current minimum productivity and efficiency standards no lower than 3500 encounters per FTE physician; increasing the statewide median cost cap from 105% to 120%, ~~or~~ a one-time re-basing of rates utilizing 2018 FQHC cost reports, or another alternative payment method acceptable to the Centers for Medicare and Medicaid Services and the FQHCs, including an across the board percentage increase to existing rates.

(Source: P.A. 101-636, eff. 6-10-20.)

Article 15.

Section 15-1. Short title. This Act may be cited as the

COVID-19 Medically Necessary Diagnostic Testing Act.

Section 15-5. Findings. The General Assembly finds that COVID-19 has infected hundreds of thousands of Illinois residents and taken the lives of tens of thousands all within less than a year's time. Nursing home residents are at particular risk of the virus due to many factors, and routine testing among residents and staff is critical to control the spread within facilities. Nursing facilities are required by federal and State regulation to conduct COVID-19 routine testing at specified intervals.

The General Assembly finds that some insurance companies are denying coverage of routine COVID-19 testing for insured staff because it is not deemed medically necessary.

The General Assembly also finds that diagnostic testing for COVID-19 is a medically necessary basic health care service for nursing home employees, regardless of whether the employee has symptoms of COVID-19 infection or is asymptomatic, or whether the employee has a known or suspected exposure to a person with COVID-19.

The General Assembly therefore finds and declares that routine COVID-19 testing of nursing home facility employees, as mandated by State or federal laws, rules, regulations, or guidance, is medically necessary and insurance companies must cover the cost associated with such testing.

Section 15-10. Applicability. This Act applies to companies as defined in subsection (e) of Section 2 of the Illinois Insurance Code, which offer insurance policies and coverage to employees of long-term care facilities as defined in Section 1-113 of the Nursing Home Care Act.

Section 15-15. Definitions.

"COVID-19" means the disease caused by SARS-CoV-2 or any further mutation.

"Diagnostic testing" means testing administered for the purposes of diagnosing COVID-19 or a related virus and the administration of such tests if the test is:

(1) approved, cleared, or authorized under Section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, and 360bbb-3);

(2) the subject of a request or intended request for emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb-3), until the emergency use authorization request has been denied or the developer of the test does not submit a request within a reasonable timeframe;

(3) developed and authorized by a state that has notified the Secretary of the United States Department of Health and Human Services of its intention to review a test intended to diagnose COVID-19; or

(4) determined by the Secretary of the United States

Department of Health and Human Services or the Director of the Centers for Disease Control and Prevention as appropriate for the diagnosis of COVID-19.

"Enrollee" means a nursing home employee who is covered by a health plan.

"Health plan" means all policies, contracts, and certificates of health insurance coverage that are or will be enforced, issued, delivered, amended, or renewed in this State and subject to the authority of the Director of Insurance under any insurance law.

"Nursing home employee" means anyone employed by or under contract with a long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or under contract with a third party to provide services within a long-term care facility.

"Testing provider" means any professional person, organization, health facility, or other person or institution licensed or authorized by the State to deliver or furnish COVID-19 diagnostic tests. Testing providers include physicians and other primary care providers; urgent care centers; State-run or county-run clinics or testing sites; pharmacies; university laboratories; hospital emergency departments; skilled nursing facilities; and any other outpatient provider setting for which the diagnosis of COVID-19 is within the scope of the provider's State licensure or authorization.

Section 15-20. Diagnostic testing.

(a) A health plan shall not impose utilization management requirements on COVID-19 diagnostic tests for nursing home employees.

(b) A health plan may inquire as to whether an enrollee is a nursing home employee as defined in this Act, but shall require no further evidence or verification of the enrollee's nursing home employee status when determining whether the enrollee is a nursing home employee.

(c) Medically necessary COVID-19 testing is urgent care, and health plans shall not extend the applicable wait time for a COVID-19 testing appointment, even if such an extension would otherwise be permitted.

(d) A health plan shall reimburse the testing provider for medically necessary COVID-19 testing at the contracted rate if the health plan has a contract with the testing provider. If the health plan and the testing provider do not have a contract that encompasses COVID-19 testing, the health plan shall reimburse the provider at the provider's cash price, when required by federal law. In all other instances, the health plan shall reimburse the provider for the reasonable and customary value of the services.

(e) Changes to a contract between a health plan and a provider delegating financial risk for COVID-19 diagnostic testing, including related items and services, shall be

considered a material change to the parties' contract. A health plan shall not delegate the financial risk to a contracted provider for the cost of the enrollee services provided under this Section unless the parties have negotiated and agreed upon a new provision of the parties' contract.

(f) The timeframes specified in the Illinois Insurance Code apply for the submission and payment of claims for COVID-19 diagnostic testing and related items and services. A health plan shall not delay or deny payment of a testing provider's claim for services received by an enrollee in accordance with this Section.

(g) For purposes of the submission of claims in accordance with this Section, "provider" includes the State of Illinois, university laboratories, and State-run or county-run clinics or other testing sites.

(h) Failure by a health plan to comply with the requirements of this Act may constitute a basis for disciplinary action against the health plan. The Director of Insurance shall have all the civil, criminal, and administrative remedies available under the Illinois Insurance Code.

Article 30.

Section 30-5. The Nursing Home Care Act is amended by changing Section 3-206 as follows:

(210 ILCS 45/3-206) (from Ch. 111 1/2, par. 4153-206)

Sec. 3-206. The Department shall prescribe a curriculum for training nursing assistants, habilitation aides, and child care aides.

(a) No person, except a volunteer who receives no compensation from a facility and is not included for the purpose of meeting any staffing requirements set forth by the Department, shall act as a nursing assistant, habilitation aide, or child care aide in a facility, nor shall any person, under any other title, not licensed, certified, or registered to render medical care by the Department of Financial and Professional Regulation, assist with the personal, medical, or nursing care of residents in a facility, unless such person meets the following requirements:

(1) Be at least 16 years of age, of temperate habits and good moral character, honest, reliable and trustworthy.

(2) Be able to speak and understand the English language or a language understood by a substantial percentage of the facility's residents.

(3) Provide evidence of employment or occupation, if any, and residence for 2 years prior to his present employment.

(4) Have completed at least 8 years of grade school or provide proof of equivalent knowledge.

(5) Begin a current course of training for nursing assistants, habilitation aides, or child care aides, approved by the Department, within 45 days of initial employment in the capacity of a nursing assistant, habilitation aide, or child care aide at any facility. Such courses of training shall be successfully completed within 120 days of initial employment in the capacity of nursing assistant, habilitation aide, or child care aide at a facility. Nursing assistants, habilitation aides, and child care aides who are enrolled in approved courses in community colleges or other educational institutions on a term, semester or trimester basis, shall be exempt from the 120-day completion time limit. The Department shall adopt rules for such courses of training. These rules shall include procedures for facilities to carry on an approved course of training within the facility. The Department shall allow an individual to satisfy the supervised clinical experience requirement for placement on the Health Care Worker Registry under 77 Ill. Adm. Code 300.663 through supervised clinical experience at an assisted living establishment licensed under the Assisted Living and Shared Housing Act. The Department shall adopt rules requiring that the Health Care Worker Registry include information identifying where an individual on the Health Care Worker Registry received his or her clinical training.

The Department may accept comparable training in lieu

of the 120-hour course for student nurses, foreign nurses, military personnel, or employees of the Department of Human Services.

The Department shall accept on-the-job experience in lieu of clinical training from any individual who participated in the temporary nursing assistant program during the COVID-19 pandemic before the end date of the temporary nursing assistant program and left the program in good standing, and the Department shall notify all approved certified nurse assistant training programs in the State of this requirement. The individual shall receive one hour of credit for every hour employed as a temporary nursing assistant, up to 40 total hours, and shall be permitted 90 days after the end date of the temporary nursing assistant program to enroll in an approved certified nursing assistant training program and 240 days to successfully complete the certified nursing assistant training program. Temporary nursing assistants who enroll in a certified nursing assistant training program within 90 days of the end of the temporary nursing assistant program may continue to work as a nursing assistant for up to 240 days after enrollment in the certified nursing assistant training program. As used in this Section, "temporary nursing assistant program" means the program implemented by the Department of Public Health by emergency rule, as listed in 44 Ill. Reg. 7936, effective April 21, 2020.

The facility shall develop and implement procedures, which shall be approved by the Department, for an ongoing review process, which shall take place within the facility, for nursing assistants, habilitation aides, and child care aides.

At the time of each regularly scheduled licensure survey, or at the time of a complaint investigation, the Department may require any nursing assistant, habilitation aide, or child care aide to demonstrate, either through written examination or action, or both, sufficient knowledge in all areas of required training. If such knowledge is inadequate the Department shall require the nursing assistant, habilitation aide, or child care aide to complete inservice training and review in the facility until the nursing assistant, habilitation aide, or child care aide demonstrates to the Department, either through written examination or action, or both, sufficient knowledge in all areas of required training.

(6) Be familiar with and have general skills related to resident care.

(a-0.5) An educational entity, other than a secondary school, conducting a nursing assistant, habilitation aide, or child care aide training program shall initiate a criminal history record check in accordance with the Health Care Worker Background Check Act prior to entry of an individual into the training program. A secondary school may initiate a criminal

history record check in accordance with the Health Care Worker Background Check Act at any time during or after a training program.

(a-1) Nursing assistants, habilitation aides, or child care aides seeking to be included on the Health Care Worker Registry under the Health Care Worker Background Check Act on or after January 1, 1996 must authorize the Department of Public Health or its designee to request a criminal history record check in accordance with the Health Care Worker Background Check Act and submit all necessary information. An individual may not newly be included on the Health Care Worker Registry unless a criminal history record check has been conducted with respect to the individual.

(b) Persons subject to this Section shall perform their duties under the supervision of a licensed nurse.

(c) It is unlawful for any facility to employ any person in the capacity of nursing assistant, habilitation aide, or child care aide, or under any other title, not licensed by the State of Illinois to assist in the personal, medical, or nursing care of residents in such facility unless such person has complied with this Section.

(d) Proof of compliance by each employee with the requirements set out in this Section shall be maintained for each such employee by each facility in the individual personnel folder of the employee. Proof of training shall be obtained only from the Health Care Worker Registry.

(e) Each facility shall obtain access to the Health Care Worker Registry's web application, maintain the employment and demographic information relating to each employee, and verify by the category and type of employment that each employee subject to this Section meets all the requirements of this Section.

(f) Any facility that is operated under Section 3-803 shall be exempt from the requirements of this Section.

(g) Each skilled nursing and intermediate care facility that admits persons who are diagnosed as having Alzheimer's disease or related dementias shall require all nursing assistants, habilitation aides, or child care aides, who did not receive 12 hours of training in the care and treatment of such residents during the training required under paragraph (5) of subsection (a), to obtain 12 hours of in-house training in the care and treatment of such residents. If the facility does not provide the training in-house, the training shall be obtained from other facilities, community colleges or other educational institutions that have a recognized course for such training. The Department shall, by rule, establish a recognized course for such training. The Department's rules shall provide that such training may be conducted in-house at each facility subject to the requirements of this subsection, in which case such training shall be monitored by the Department.

The Department's rules shall also provide for circumstances and procedures whereby any person who has

received training that meets the requirements of this subsection shall not be required to undergo additional training if he or she is transferred to or obtains employment at a different facility or a facility other than a long-term care facility but remains continuously employed for pay as a nursing assistant, habilitation aide, or child care aide. Individuals who have performed no nursing or nursing-related services for a period of 24 consecutive months shall be listed as "inactive" and as such do not meet the requirements of this Section. Licensed sheltered care facilities shall be exempt from the requirements of this Section.

An individual employed during the COVID-19 pandemic as a nursing assistant in accordance with any Executive Orders, emergency rules, or policy memoranda related to COVID-19 shall be assumed to meet competency standards and may continue to be employed as a certified nurse assistant when the pandemic ends and the Executive Orders or emergency rules lapse. Such individuals shall be listed on the Department's Health Care Worker Registry website as "active".

(Source: P.A. 100-297, eff. 8-24-17; 100-432, eff. 8-25-17; 100-863, eff. 8-14-18.)

Article 40.

Section 40-5. The Nurse Practice Act is amended by changing Sections 55-35 and 60-40 as follows:

(225 ILCS 65/55-35)

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

Sec. 55-35. Continuing education for LPN licensees. The Department may adopt rules of continuing education for licensed practical nurses that require 20 hours of continuing education per 2-year license renewal cycle. The rules shall address variances in part or in whole for good cause, including without limitation illness or hardship. The continuing education rules must ensure that licensees are given the opportunity to participate in programs sponsored by or through their State or national professional associations, hospitals, or other providers of continuing education. The continuing education rules must allow for a licensee to complete all required hours of continuing education in an online format. Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.

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

(225 ILCS 65/60-40)

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

Sec. 60-40. Continuing education for RN licensees. The Department may adopt rules of continuing education for registered professional nurses licensed under this Act that require 20 hours of continuing education per 2-year license

renewal cycle. The rules shall address variances in part or in whole for good cause, including without limitation illness or hardship. The continuing education rules must ensure that licensees are given the opportunity to participate in programs sponsored by or through their State or national professional associations, hospitals, or other providers of continuing education. The continuing education rules must allow for a licensee to complete all required hours of continuing education in an online format. Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.

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

Section 40-10. The Nursing Home Administrators Licensing and Disciplinary Act is amended by changing Section 11 as follows:

(225 ILCS 70/11) (from Ch. 111, par. 3661)

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

Sec. 11. Expiration; renewal; continuing education. The expiration date and renewal period for each license issued under this Act shall be set by rule.

Each licensee shall provide proof of having obtained 36 hours of continuing education in the 2 year period preceding the renewal date of the license as a condition of license

renewal. The continuing education rules must allow for a licensee to complete all required hours of continuing education in an online format. The continuing education requirement may be waived in part or in whole for such good cause as may be determined by rule.

Any continuing education course for nursing home administrators approved by the National Continuing Education Review Service of the National Association of Boards of Examiners of Nursing Home Administrators will be accepted toward satisfaction of these requirements.

Any continuing education course for nursing home administrators sponsored by the Life Services Network of Illinois, Illinois Council on Long Term Care, County Nursing Home Association of Illinois, Illinois Health Care Association, Illinois Chapter of American College of Health Care Administrators, and the Illinois Nursing Home Administrators Association will be accepted toward satisfaction of these requirements.

Any school, college or university, State agency, or other entity may apply to the Department for approval as a continuing education sponsor. Criteria for qualification as a continuing education sponsor shall be established by rule.

It shall be the responsibility of each continuing education sponsor to maintain records, as prescribed by rule, to verify attendance.

The Department shall establish by rule a means for the

verification of completion of the continuing education required by this Section. This verification may be accomplished through audits of records maintained by registrants; by requiring the filing of continuing education certificates with the Department; or by other means established by the Department.

Any nursing home administrator who has permitted his or her license to expire or who has had his or her license on inactive status may have his or her license restored by making application to the Department and filing proof acceptable to the Department, as defined by rule, of his or her fitness to have his or her license restored and by paying the required fee. Proof of fitness may include evidence certifying to active lawful practice in another jurisdiction satisfactory to the Department and by paying the required restoration fee.

However, any nursing home administrator whose license expired while he or she was (1) in federal service on active duty with the Armed Forces of the United States, or the State Militia called into service or training, or (2) in training or education under the supervision of the United States preliminary to induction into the military services, may have his or her license renewed or restored without paying any lapsed renewal fees if within 2 years after honorable termination of such service, training or education, he or she furnishes the Department with satisfactory evidence to the effect that he or she has been so engaged and that his or her

service, training or education has been so terminated.

(Source: P.A. 95-703, eff. 12-31-07.)

Article 99.

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