

1 AN ACT concerning health.

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

4 Title I. General Provisions

5 Article 1.

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

8 Section 1-5. Findings.

9 "We, the People of the State of Illinois in order to
10 provide for the health, safety and welfare of the people;
11 maintain a representative and orderly government; eliminate
12 poverty and inequality; assure legal, social and economic
13 justice; provide opportunity for the fullest development of
14 the individual; insure domestic tranquility; provide for the
15 common defense; and secure the blessings of freedom and
16 liberty to ourselves and our posterity - do ordain and
17 establish this Constitution for the State of Illinois."

18 The Illinois Legislative Black Caucus finds that, in order
19 to improve the health outcomes of Black residents in the State
20 of Illinois, it is essential to dramatically reform the
21 State's health and human service system. For over 3 decades,

1 multiple health studies have found that health inequities at
2 their very core are due to racism. As early as 1998 research
3 demonstrated that Black Americans received less health care
4 than white Americans because doctors treated patients
5 differently on the basis of race. Yet, Illinois' health and
6 human service system disappointingly continues to perpetuate
7 health disparities among Black Illinoisans of all ages,
8 genders, and socioeconomic status.

9 In July 2020, Trinity Health announced its plans to close
10 Mercy Hospital, an essential resource serving the Chicago
11 South Side's predominantly Black residents. Trinity Health
12 argued that this closure would have no impact on health access
13 but failed to understand the community's needs. Closure of
14 Mercy Hospital would only serve to create a health access
15 desert and exacerbate existing health disparities. On December
16 15, 2020, after hearing from community members and advocates,
17 the Health Facilities and Services Review Board unanimously
18 voted to deny closure efforts, yet Trinity still seeks to
19 cease Mercy's operations.

20 Prior to COVID-19, much of the social and political
21 attention surrounding the nationwide opioid epidemic focused
22 on the increase in overdose deaths among white, middle-class,
23 suburban and rural users; the impact of the epidemic in Black
24 communities was largely unrecognized. Research has shown rates
25 of opioid use at the national scale are higher for whites than
26 they are for Blacks, yet rates of opioid deaths are higher

1 among Blacks (43%) than whites (22%). The COVID-19 pandemic
2 will likely exacerbate this situation due to job loss,
3 stay-at-home orders, and ongoing mitigation efforts creating a
4 lack of physical access to addiction support and harm
5 reduction groups.

6 In 2018, the Illinois Department of Public Health reported
7 that Black women were about 6 times as likely to die from a
8 pregnancy-related cause as white women. Of those, 72% of
9 pregnancy-related deaths and 93% of violent
10 pregnancy-associated deaths were deemed preventable. Between
11 2016 and 2017, Black women had the highest rate of severe
12 maternal morbidity with a rate of 101.5 per 10,000 deliveries,
13 which is almost 3 times as high as the rate for white women.

14 In the City of Chicago, African American and Latinx
15 populations are suffering from higher rates of AIDS/HIV
16 compared to the general population. Recent data places HIV as
17 one of the top 5 leading causes of death in African American
18 women between the ages of 35 to 44 and the seventh ranking
19 cause in African American women between the ages of 20 to 34.
20 Among the Latinx population, nearly 20% with HIV exclusively
21 depend on indigenous-led and staffed organizations for
22 services.

23 Cardiovascular disease (CVD) accounts for more deaths in
24 Illinois than any other cause of death, according to the
25 Illinois Department of Public Health; CVD is the leading cause
26 of death among Black residents. According to the Kaiser Family

1 Foundation (KFF), for every 100,000 people, 224 Black
2 Illinoisans die of CVD compared to 158 white Illinoisans.
3 Cancer, the second leading cause of death in Illinois, too is
4 pervasive among African Americans. In 2019, an estimated
5 606,880 Americans, or 1,660 people a day, died of cancer; the
6 American Cancer Society estimated 24,410 deaths occurred in
7 Illinois. KFF estimates that, out of every 100,000 people, 191
8 Black Illinoisans die of cancer compared to 152 white
9 Illinoisans.

10 Black Americans suffer at much higher rates from chronic
11 diseases, including diabetes, hypertension, heart disease,
12 asthma, and many cancers. Utilizing community health workers
13 in patient education and chronic disease management is needed
14 to close these health disparities. Studies have shown that
15 diabetes patients in the care of a community health worker
16 demonstrate improved knowledge and lifestyle and
17 self-management behaviors, as well as decreases in the use of
18 the emergency department. A study of asthma control among
19 Black adolescents concluded that asthma control was reduced by
20 35% among adolescents working with community health workers,
21 resulting in a savings of \$5.58 per dollar spent on the
22 intervention. A study of the return on investment for
23 community health workers employed in Colorado showed that,
24 after a 9-month period, patients working with community health
25 workers had an increased number of primary care visits and a
26 decrease in urgent and inpatient care. Utilization of

1 community health workers led to a \$2.38 return on investment
2 for every dollar invested in community health workers.

3 Adverse childhood experiences (ACEs) are traumatic
4 experiences occurring during childhood that have been found to
5 have a profound effect on a child's developing brain structure
6 and body which may result in poor health during a person's
7 adulthood. ACEs studies have found a strong correlation
8 between the number of ACEs and a person's risk for disease and
9 negative health behaviors, including suicide, depression,
10 cancer, stroke, ischemic heart disease, diabetes, autoimmune
11 disease, smoking, substance abuse, interpersonal violence,
12 obesity, unplanned pregnancies, lower educational achievement,
13 workplace absenteeism, and lower wages. Data also shows that
14 approximately 20% of African American and Hispanic adults in
15 Illinois reported 4 or more ACEs, compared to 13% of
16 non-Hispanic whites. Long-standing ACE interventions include
17 tools such as trauma-informed care. Trauma-informed care has
18 been promoted and established in communities across the
19 country on a bipartisan basis, including in the states of
20 California, Florida, Massachusetts, Missouri, Oregon,
21 Pennsylvania, Washington, and Wisconsin. Several federal
22 agencies have integrated trauma-informed approaches in their
23 programs and grants which should be leveraged by the State.

24 According to a 2019 Rush University report, a Black
25 person's life expectancy on average is less when compared to a
26 white person's life expectancy. For instance, when comparing

1 life expectancy in Chicago's Austin neighborhood to the
2 Chicago Loop, there is a difference of 11 years between Black
3 life expectancy (71 years) and white life expectancy (82
4 years).

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

14 In the field of medicine, a historically racist
15 profession, Black medical professionals have commonly been
16 ostracized. In 1934, Dr. Roland B. Scott was the first African
17 American to pass the pediatric board exam, yet when he applied
18 for membership with the American Academy of Pediatrics he was
19 rejected multiple times. Few medical organizations have
20 confronted the roles they played in blocking opportunities for
21 Black advancement in the medical profession until the formal
22 apologies of the American Medical Association in 2008. For
23 decades, organizations like the AMA predicated their
24 membership on joining a local state medical society, several
25 of which excluded Black physicians.

26 In 2010, the General Assembly, in partnership with

1 Treatment Alternatives for Safe Communities, published the
2 Disproportionate Justice Impact Study. The study examined the
3 impact of Illinois drug laws on racial and ethnic groups and
4 the resulting over-representation of racial and ethnic minority
5 groups in the Illinois criminal justice system. Unsurprisingly
6 and disappointingly, the study confirmed decades long
7 injustices, such as nonwhites being arrested at a higher rate
8 than whites relative to their representation in the general
9 population throughout Illinois.

10 All together, the above mentioned only begins to capture a
11 part of a larger system of racial injustices and inequities.
12 The General Assembly and the people of Illinois are urged to
13 recognize while racism is a core fault of the current health
14 and human service system, that it is a pervasive disease
15 affecting a multiplitude of institutions which truly drive
16 systematic health inequities: education, child care, criminal
17 justice, affordable housing, environmental justice, and job
18 security and so forth. For persons to live up to their full
19 human potential, their rights to quality of life, health care,
20 a quality job, a fair wage, housing, and education must not be
21 inhibited.

22 Therefore, the Illinois Legislative Black Caucus, as
23 informed by the Senate's Health and Human Service Pillar
24 subject matter hearings, seeks to remedy a fraction of a much
25 larger broken system by addressing access to health care,
26 hospital closures, managed care organization reform, community

1 health worker certification, maternal and infant mortality,
2 mental and substance abuse treatment, hospital reform, and
3 medical implicit bias in the Illinois Health Care and Human
4 Service Reform Act. This Act shall achieve needed change
5 through the use of, but not limited to, the Medicaid Managed
6 Care Oversight Commission, the Health and Human Services Task
7 Force, and a hospital closure moratorium, in order to address
8 Illinois' long-standing health inequities.

9 Title II. Community Health Workers

10 Article 5.

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

14 Section 5-5. Definition. In this Act, "community health
15 worker" means a frontline public health worker who is a
16 trusted member or has an unusually close understanding of the
17 community served. This trusting relationship enables the
18 community health worker to serve as a liaison, link, and
19 intermediary between health and social services and the
20 community to facilitate access to services and improve the
21 quality and cultural competence of service delivery. A
22 community health worker also builds individual and community

1 capacity by increasing health knowledge and self-sufficiency
2 through a range of activities, including outreach, community
3 education, informal counseling, social support, and advocacy.
4 A community health worker shall have the following core
5 competencies:

6 (1) communication;

7 (2) interpersonal skills and relationship building;

8 (3) service coordination and navigation skills;

9 (4) capacity-building;

10 (5) advocacy;

11 (6) presentation and facilitation skills;

12 (7) organizational skills; cultural competency;

13 (8) public health knowledge;

14 (9) understanding of health systems and basic
15 diseases;

16 (10) behavioral health issues; and

17 (11) field experience.

18 Nothing in this definition shall be construed to authorize
19 a community health worker to provide direct care or treatment
20 to any person or to perform any act or service for which a
21 license issued by a professional licensing board is required.

22 Section 5-10. Community health worker training.

23 (a) Community health workers shall be provided with
24 multi-tiered academic and community-based training
25 opportunities that lead to the mastery of community health

1 worker core competencies.

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

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

17 (d) Community health workers may need to undergo
18 additional training, including, but not limited to, asthma,
19 diabetes, maternal child health, behavioral health, and social
20 determinants of health training. Multi-tiered training
21 approaches shall provide opportunities that build on each
22 other and prepare community health workers for career pathways
23 both within the community health worker profession and within
24 allied professions.

25 Section 5-15. Illinois Community Health Worker

1 Certification Board.

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

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

20 (c) The Board shall propose a certification process for
21 and be authorized to approve training from community-based
22 organizations, in conjunction with a statewide organization
23 representing community health workers, and academic
24 institutions, in consultation with the Illinois State Board of
25 Education, the Illinois Community College Board and the
26 Illinois Board of Higher Education. The Board shall base

1 training approval on core competencies, best practices, and
2 affordability. In addition, the Board shall maintain a
3 registry of certification records for individually certified
4 community health workers.

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

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

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

19 Section 5-20. Reimbursement. Community health worker
20 services shall be covered under the medical assistance
21 program, subject to appropriation, for persons who are
22 otherwise eligible for medical assistance. The Department of
23 Healthcare and Family Services shall develop services,
24 including, but not limited to, care coordination and
25 diagnosis-related patient services, for which community health

1 workers will be eligible for reimbursement and shall request
2 approval from the federal Centers for Medicare and Medicaid
3 Services to reimburse community health worker services under
4 the medical assistance program. For reimbursement under the
5 medical assistance program, a community health worker must
6 work under the supervision of an enrolled medical program
7 provider, as specified by the Department, and certification
8 shall be required for reimbursement. The supervision of
9 enrolled medical program providers and certification are not
10 required for community health workers who receive
11 reimbursement through managed care administrative moneys.
12 Noncertified community health workers are reimbursable at the
13 discretion of managed care entities following availability of
14 community health worker certification. In addition, the
15 Department of Healthcare and Family Services shall amend its
16 contracts with managed care entities to allow managed care
17 entities to employ community health workers or subcontract
18 with community-based organizations that employ community
19 health workers.

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

24 Section 5-25. Rules. The Department of Public Health and

1 the Department of Healthcare and Family Services may adopt
2 rules for the implementation and administration of this Act.

3 Title III. Hospital Reform

4 Article 10.

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

7 (210 ILCS 85/10.4) (from Ch. 111 1/2, par. 151.4)

8 Sec. 10.4. Medical staff privileges.

9 (a) Any hospital licensed under this Act or any hospital
10 organized under the University of Illinois Hospital Act shall,
11 prior to the granting of any medical staff privileges to an
12 applicant, or renewing a current medical staff member's
13 privileges, request of the Director of Professional Regulation
14 information concerning the licensure status, proper
15 credentials, required certificates, and any disciplinary
16 action taken against the applicant's or medical staff member's
17 license, except: (1) for medical personnel who enter a
18 hospital to obtain organs and tissues for transplant from a
19 donor in accordance with the Illinois Anatomical Gift Act; or
20 (2) for medical personnel who have been granted disaster
21 privileges pursuant to the procedures and requirements
22 established by rules adopted by the Department. Any hospital

1 and any employees of the hospital or others involved in
2 granting privileges who, in good faith, grant disaster
3 privileges pursuant to this Section to respond to an emergency
4 shall not, as a result of their acts or omissions, be liable
5 for civil damages for granting or denying disaster privileges
6 except in the event of willful and wanton misconduct, as that
7 term is defined in Section 10.2 of this Act. Individuals
8 granted privileges who provide care in an emergency situation,
9 in good faith and without direct compensation, shall not, as a
10 result of their acts or omissions, except for acts or
11 omissions involving willful and wanton misconduct, as that
12 term is defined in Section 10.2 of this Act, on the part of the
13 person, be liable for civil damages. The Director of
14 Professional Regulation shall transmit, in writing and in a
15 timely fashion, such information regarding the license of the
16 applicant or the medical staff member, including the record of
17 imposition of any periods of supervision or monitoring as a
18 result of alcohol or substance abuse, as provided by Section
19 23 of the Medical Practice Act of 1987, and such information as
20 may have been submitted to the Department indicating that the
21 application or medical staff member has been denied, or has
22 surrendered, medical staff privileges at a hospital licensed
23 under this Act, or any equivalent facility in another state or
24 territory of the United States. The Director of Professional
25 Regulation shall define by rule the period for timely response
26 to such requests.

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

12 (b) All hospitals licensed under this Act, except county
13 hospitals as defined in subsection (c) of Section 15-1 of the
14 Illinois Public Aid Code, shall comply with, and the medical
15 staff bylaws of these hospitals shall include rules consistent
16 with, the provisions of this Section in granting, limiting,
17 renewing, or denying medical staff membership and clinical
18 staff privileges. Hospitals that require medical staff members
19 to possess faculty status with a specific institution of
20 higher education are not required to comply with subsection
21 (1) below when the physician does not possess faculty status.

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

25 (A) Written procedures relating to the acceptance
26 and processing of pre-applicants or applicants for

1 medical staff membership, which should be contained in
2 medical staff bylaws.

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

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

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

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

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

20 (A) A written notice of an adverse decision.

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

25 (C) A statement of the medical staff member's
26 right to request a fair hearing on the adverse

1 decision before a hearing panel whose membership is
2 mutually agreed upon by the medical staff and the
3 hospital governing board. The hearing panel shall have
4 independent authority to recommend action to the
5 hospital governing board. Upon the request of the
6 medical staff member or the hospital governing board,
7 the hearing panel shall make findings concerning the
8 nature of each basis for any adverse decision
9 recommended to and accepted by the hospital governing
10 board.

11 (i) Nothing in this subparagraph (C) limits a
12 hospital's or medical staff's right to summarily
13 suspend, without a prior hearing, a person's
14 medical staff membership or clinical privileges if
15 the continuation of practice of a medical staff
16 member constitutes an immediate danger to the
17 public, including patients, visitors, and hospital
18 employees and staff. In the event that a hospital
19 or the medical staff imposes a summary suspension,
20 the Medical Executive Committee, or other
21 comparable governance committee of the medical
22 staff as specified in the bylaws, must meet as
23 soon as is reasonably possible to review the
24 suspension and to recommend whether it should be
25 affirmed, lifted, expunged, or modified if the
26 suspended physician requests such review. A

1 summary suspension may not be implemented unless
2 there is actual documentation or other reliable
3 information that an immediate danger exists. This
4 documentation or information must be available at
5 the time the summary suspension decision is made
6 and when the decision is reviewed by the Medical
7 Executive Committee. If the Medical Executive
8 Committee recommends that the summary suspension
9 should be lifted, expunged, or modified, this
10 recommendation must be reviewed and considered by
11 the hospital governing board, or a committee of
12 the board, on an expedited basis. Nothing in this
13 subparagraph (C) shall affect the requirement that
14 any requested hearing must be commenced within 15
15 days after the summary suspension and completed
16 without delay unless otherwise agreed to by the
17 parties. A fair hearing shall be commenced within
18 15 days after the suspension and completed without
19 delay, except that when the medical staff member's
20 license to practice has been suspended or revoked
21 by the State's licensing authority, no hearing
22 shall be necessary.

23 (ii) Nothing in this subparagraph (C) limits a
24 medical staff's right to permit, in the medical
25 staff bylaws, summary suspension of membership or
26 clinical privileges in designated administrative

1 circumstances as specifically approved by the
2 medical staff. This bylaw provision must
3 specifically describe both the administrative
4 circumstance that can result in a summary
5 suspension and the length of the summary
6 suspension. The opportunity for a fair hearing is
7 required for any administrative summary
8 suspension. Any requested hearing must be
9 commenced within 15 days after the summary
10 suspension and completed without delay. Adverse
11 decisions other than suspension or other
12 restrictions on the treatment or admission of
13 patients may be imposed summarily and without a
14 hearing under designated administrative
15 circumstances as specifically provided for in the
16 medical staff bylaws as approved by the medical
17 staff.

18 (iii) If a hospital exercises its option to
19 enter into an exclusive contract and that contract
20 results in the total or partial termination or
21 reduction of medical staff membership or clinical
22 privileges of a current medical staff member, the
23 hospital shall provide the affected medical staff
24 member 60 days prior notice of the effect on his or
25 her medical staff membership or privileges. An
26 affected medical staff member desiring a hearing

1 under subparagraph (C) of this paragraph (2) must
2 request the hearing within 14 days after the date
3 he or she is so notified. The requested hearing
4 shall be commenced and completed (with a report
5 and recommendation to the affected medical staff
6 member, hospital governing board, and medical
7 staff) within 30 days after the date of the
8 medical staff member's request. If agreed upon by
9 both the medical staff and the hospital governing
10 board, the medical staff bylaws may provide for
11 longer time periods.

12 (C-5) All peer review used for the purpose of
13 credentialing, privileging, disciplinary action, or
14 other recommendations affecting medical staff
15 membership or exercise of clinical privileges, whether
16 relying in whole or in part on internal or external
17 reviews, shall be conducted in accordance with the
18 medical staff bylaws and applicable rules,
19 regulations, or policies of the medical staff. If
20 external review is obtained, any adverse report
21 utilized shall be in writing and shall be made part of
22 the internal peer review process under the bylaws. The
23 report shall also be shared with a medical staff peer
24 review committee and the individual under review. If
25 the medical staff peer review committee or the
26 individual under review prepares a written response to

1 the report of the external peer review within 30 days
2 after receiving such report, the governing board shall
3 consider the response prior to the implementation of
4 any final actions by the governing board which may
5 affect the individual's medical staff membership or
6 clinical privileges. Any peer review that involves
7 willful or wanton misconduct shall be subject to civil
8 damages as provided for under Section 10.2 of this
9 Act.

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

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

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

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

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

22 (G) Notice given 15 days before implementation of
23 an adverse medical staff membership or clinical
24 privileges decision based substantially on economic
25 factors. This notice shall be given after the medical
26 staff member exhausts all applicable procedures under

1 this Section, including item (iii) of subparagraph (C)
2 of this paragraph (2), and under the medical staff
3 bylaws in order to allow sufficient time for the
4 orderly provision of patient care.

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

16 (3) Every adverse medical staff membership and
17 clinical privilege decision based substantially on
18 economic factors shall be reported to the Hospital
19 Licensing Board before the decision takes effect. These
20 reports shall not be disclosed in any form that reveals
21 the identity of any hospital or physician. These reports
22 shall be utilized to study the effects that hospital
23 medical staff membership and clinical privilege decisions
24 based upon economic factors have on access to care and the
25 availability of physician services. The Hospital Licensing
26 Board shall submit an initial study to the Governor and

1 the General Assembly by January 1, 1996, and subsequent
2 reports shall be submitted periodically thereafter.

3 (4) As used in this Section:

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

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

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

13 "Privilege" means permission to provide medical or
14 other patient care services and permission to use hospital
15 resources, including equipment, facilities and personnel
16 that are necessary to effectively provide medical or other
17 patient care services. This definition shall not be
18 construed to require a hospital to acquire additional
19 equipment, facilities, or personnel to accommodate the
20 granting of privileges.

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

24 (c) All hospitals shall consult with the medical staff
25 prior to closing membership in the entire or any portion of the
26 medical staff or a department. If the hospital closes

1 membership in the medical staff, any portion of the medical
2 staff, or the department over the objections of the medical
3 staff, then the hospital shall provide a detailed written
4 explanation for the decision to the medical staff 10 days
5 prior to the effective date of any closure. No applications
6 need to be provided when membership in the medical staff or any
7 relevant portion of the medical staff is closed.

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

9 Article 15.

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

12 (20 ILCS 2215/4-4) (from Ch. 111 1/2, par. 6504-4)

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

17 (b) The Department of Public Health shall require
18 hospitals to post, either by physical or electronic means, in
19 prominent letters, ~~in letters no more than one inch in height~~
20 the established charges for services, where applicable,
21 including but not limited to the hospital's private room
22 charge, semi-private room charge, charge for a room with 3 or
23 more beds, intensive care room charges, emergency room charge,

1 operating room charge, electrocardiogram charge, anesthesia
2 charge, chest x-ray charge, blood sugar charge, blood
3 chemistry charge, tissue exam charge, blood typing charge and
4 Rh factor charge. The definitions of each charge to be posted
5 shall be determined by the Department.

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

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

9 (210 ILCS 85/6) (from Ch. 111 1/2, par. 147)

10 Sec. 6. (a) Upon receipt of an application for a permit to
11 establish a hospital the Director shall issue a permit if he
12 finds (1) that the applicant is fit, willing, and able to
13 provide a proper standard of hospital service for the
14 community with particular regard to the qualification,
15 background, and character of the applicant, (2) that the
16 financial resources available to the applicant demonstrate an
17 ability to construct, maintain, and operate a hospital in
18 accordance with the standards, rules, and regulations adopted
19 pursuant to this Act, and (3) that safeguards are provided
20 which assure hospital operation and maintenance consistent
21 with the public interest having particular regard to safe,
22 adequate, and efficient hospital facilities and services.

23 The Director may request the cooperation of county and
24 multiple-county health departments, municipal boards of

1 health, and other governmental and non-governmental agencies
2 in obtaining information and in conducting investigations
3 relating to such applications.

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

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

11 (b) Upon receipt of an application for license to open,
12 conduct, operate, and maintain a hospital, the Director shall
13 issue a license if he finds the applicant and the hospital
14 facilities comply with standards, rules, and regulations
15 promulgated under this Act. A license, unless sooner suspended
16 or revoked, shall be renewable annually upon approval by the
17 Department and payment of a license fee as established
18 pursuant to Section 5 of this Act. Each license shall be issued
19 only for the premises and persons named in the application and
20 shall not be transferable or assignable. Licenses shall be
21 posted, either by physical or electronic means, in a
22 conspicuous place on the licensed premises. The Department
23 may, either before or after the issuance of a license, request
24 the cooperation of the State Fire Marshal, county and multiple
25 county health departments, or municipal boards of health to
26 make investigations to determine if the applicant or licensee

1 is complying with the minimum standards prescribed by the
2 Department. The report and recommendations of any such agency
3 shall be in writing and shall state with particularity its
4 findings with respect to compliance or noncompliance with such
5 minimum standards, rules, and regulations.

6 The Director may issue a provisional license to any
7 hospital which does not substantially comply with the
8 provisions of this Act and the standards, rules, and
9 regulations promulgated by virtue thereof provided that he
10 finds that such hospital has undertaken changes and
11 corrections which upon completion will render the hospital in
12 substantial compliance with the provisions of this Act, and
13 the standards, rules, and regulations adopted hereunder, and
14 provided that the health and safety of the patients of the
15 hospital will be protected during the period for which such
16 provisional license is issued. The Director shall advise the
17 licensee of the conditions under which such provisional
18 license is issued, including the manner in which the hospital
19 facilities fail to comply with the provisions of the Act,
20 standards, rules, and regulations, and the time within which
21 the changes and corrections necessary for such hospital
22 facilities to substantially comply with this Act, and the
23 standards, rules, and regulations of the Department relating
24 thereto shall be completed.

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

1 (210 ILCS 85/6.14c)

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

6 (1) its current license;

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

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

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

17 Each hospital shall post, either by physical or electronic
18 means, in each facility that has an emergency room, a notice in
19 a conspicuous location in the emergency room with information
20 about how to enroll in health insurance through the Illinois
21 health insurance marketplace in accordance with Sections 1311
22 and 1321 of the federal Patient Protection and Affordable Care
23 Act.

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

25 (210 ILCS 85/10.10)

1 Sec. 10.10. Nurse Staffing by Patient Acuity.

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

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

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

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

16 (b) Definitions. As used in this Section:

17 "Acuity model" means an assessment tool selected and
18 implemented by a hospital, as recommended by a nursing care
19 committee, that assesses the complexity of patient care needs
20 requiring professional nursing care and skills and aligns
21 patient care needs and nursing skills consistent with
22 professional nursing standards.

23 "Department" means the Department of Public Health.

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

1 patients.

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

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

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

16 (c) Written staffing plan.

17 (1) Every hospital shall implement a written
18 hospital-wide staffing plan, recommended by a nursing care
19 committee or committees, that provides for minimum direct
20 care professional registered nurse-to-patient staffing
21 needs for each inpatient care unit. The written
22 hospital-wide staffing plan shall include, but need not be
23 limited to, the following considerations:

24 (A) The complexity of complete care, assessment on
25 patient admission, volume of patient admissions,
26 discharges and transfers, evaluation of the progress

1 of a patient's problems, ongoing physical assessments,
2 planning for a patient's discharge, assessment after a
3 change in patient condition, and assessment of the
4 need for patient referrals.

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

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

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

18 (E) The identification of additional registered
19 nurses available for direct patient care when
20 patients' unexpected needs exceed the planned workload
21 for direct care staff.

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

26 (3) The written staffing plan shall be posted, either

1 by physical or electronic means, in a conspicuous and
2 accessible location for both patients and direct care
3 staff, as required under the Hospital Report Card Act. A
4 copy of the written staffing plan shall be provided to any
5 member of the general public upon request.

6 (d) Nursing care committee.

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

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

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

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

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

26 (C) Selection, implementation, and evaluation of a

1 written staffing plan incorporating the items
2 described in subdivisions (c)(1) and (c)(2) of this
3 Section.

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

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

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

14 (Source: P.A. 96-328, eff. 8-11-09; 97-423, eff. 1-1-12;
15 97-813, eff. 7-13-12.)

16 (210 ILCS 85/11.5)

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

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

23 (b) Each hospital shall develop a written policy statement
24 reflecting the requirements of subsection (a) and shall post,
25 either by physical or electronic means, written notices of

1 this policy in the obstetrical admitting areas of the hospital
2 by July 1, 2004. Notices posted pursuant to this Section shall
3 be posted in the predominant language or languages spoken in
4 the hospital's service area.

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

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

8 (210 ILCS 87/15)

9 Sec. 15. Language assistance services.

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

14 (1) Adopt and review annually a policy for providing
15 language assistance services to patients with language or
16 communication barriers. The policy shall include
17 procedures for providing, to the extent possible as
18 determined by the facility, the use of an interpreter
19 whenever a language or communication barrier exists,
20 except where the patient, after being informed of the
21 availability of the interpreter service, chooses to use a
22 family member or friend who volunteers to interpret. The
23 procedures shall be designed to maximize efficient use of
24 interpreters and minimize delays in providing interpreters

1 to patients. The procedures shall insure, to the extent
2 possible as determined by the facility, that interpreters
3 are available, either on the premises or accessible by
4 telephone, 24 hours a day. The facility shall annually
5 transmit to the Department of Public Health a copy of the
6 updated policy and shall include a description of the
7 facility's efforts to insure adequate and speedy
8 communication between patients with language or
9 communication barriers and staff.

10 (2) Develop, and post, either by physical or
11 electronic means, in conspicuous locations, notices that
12 advise patients and their families of the availability of
13 interpreters, the procedure for obtaining an interpreter,
14 and the telephone numbers to call for filing complaints
15 concerning interpreter service problems, including, but
16 not limited to, a TTY number for persons who are deaf or
17 hard of hearing. The notices shall be posted, at a
18 minimum, in the emergency room, the admitting area, the
19 facility entrance, and the outpatient area. Notices shall
20 inform patients that interpreter services are available on
21 request, shall list the languages most commonly
22 encountered at the facility for which interpreter services
23 are available, and shall instruct patients to direct
24 complaints regarding interpreter services to the
25 Department of Public Health, including the telephone
26 numbers to call for that purpose.

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

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

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

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

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

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

24 (5) Develop community liaison groups to enable the
25 facility and the limited-English-speaking,
26 non-English-speaking, and deaf communities to ensure the

1 adequacy of the interpreter services.

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

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

5 (210 ILCS 88/15)

6 Sec. 15. Patient notification.

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

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

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

16 (c) The sign shall be in English, and in any other language
17 that is the primary language of at least 5% of the patients
18 served by the hospital annually.

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

24 (e) Within 180 days after the effective date of this

1 amendatory Act of the 102nd General Assembly, each ~~Each~~
2 hospital must make available information regarding financial
3 assistance from the hospital in the form of either a brochure,
4 an application for financial assistance, or other written or
5 electronic material in the emergency room, ~~material in the~~
6 hospital admission, or registration area.

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

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

10 (210 ILCS 160/15)

11 Sec. 15. Workplace safety.

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

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

22 (c) A health care provider that employs a health care
23 worker shall display a notice, either by physical or
24 electronic means, stating that verbal aggression will not be

1 tolerated and physical assault will be reported to law
2 enforcement.

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

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

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

11 (410 ILCS 50/3.4)

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (12) The right to receive information in a language in
20 which she can communicate in accordance with federal law.

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

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

26 (15) The right to contact with her newborn, except

1 where necessary care must be provided to the mother or
2 infant.

3 (16) The right to receive information about
4 breastfeeding.

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

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

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

20 (b) The Department of Public Health, Department of
21 Healthcare and Family Services, Department of Children and
22 Family Services, and Department of Human Services shall post,
23 either by physical or electronic means, information about
24 these rights on their publicly available websites. Every
25 health care provider, day care center licensed under the Child
26 Care Act of 1969, Head Start, and community center shall post

1 information about these rights in a prominent place and on
2 their websites, if applicable.

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

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

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

12 (410 ILCS 50/5.2)

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

18 "You have the right not to be discriminated against by the
19 hospital due to your race, color, or national origin if these
20 characteristics are unrelated to your diagnosis or treatment.
21 If you believe this right has been violated, please call
22 (insert number for hospital grievance officer).".

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

24 Section 15-25. The Abandoned Newborn Infant Protection Act

1 is amended by changing Section 22 as follows:

2 (325 ILCS 2/22)

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

12 This Section does not apply to a hospital, fire station,
13 emergency medical facility, or police station that has a sign
14 that is consistent with the requirements of this Section that
15 is posted on the effective date of this amendatory Act of the
16 95th General Assembly.

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

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

20 (740 ILCS 45/5.1) (from Ch. 70, par. 75.1)

21 Sec. 5.1. (a) Every hospital licensed under the laws of
22 this State shall display prominently in its emergency room
23 posters giving notification of the existence and general

1 provisions of this Act. The posters may be displayed by
2 physical or electronic means. Such posters shall be provided
3 by the Attorney General.

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

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

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

13 (775 ILCS 50/5)

14 Sec. 5. Posted notice required.

15 (a) Each of the following businesses and other
16 establishments shall, upon the availability of the model
17 notice described in Section 15 of this Act, post a notice that
18 complies with the requirements of this Act in a conspicuous
19 place near the public entrance of the establishment or in
20 another conspicuous location in clear view of the public and
21 employees where similar notices are customarily posted:

22 (1) On premise consumption retailer licensees under
23 the Liquor Control Act of 1934 where the sale of alcoholic
24 liquor is the principal business carried on by the

1 licensee at the premises and primary to the sale of food.

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

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

6 (4) Intercity passenger rail or light rail stations.

7 (5) Bus stations.

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

12 (7) Emergency rooms within general acute care
13 hospitals, in which case the notice may be posted by
14 electronic means.

15 (8) Urgent care centers, in which case the notice may
16 be posted by electronic means.

17 (9) Farm labor contractors. For purposes of this Act,
18 "farm labor contractor" means: (i) any person who for a
19 fee or other valuable consideration recruits, supplies, or
20 hires, or transports in connection therewith, into or
21 within the State, any farmworker not of the contractor's
22 immediate family to work for, or under the direction,
23 supervision, or control of, a third person; or (ii) any
24 person who for a fee or other valuable consideration
25 recruits, supplies, or hires, or transports in connection
26 therewith, into or within the State, any farmworker not of

1 the contractor's immediate family, and who for a fee or
2 other valuable consideration directs, supervises, or
3 controls all or any part of the work of the farmworker or
4 who disburses wages to the farmworker. However, "farm
5 labor contractor" does not include full-time regular
6 employees of food processing companies when the employees
7 are engaged in recruiting for the companies if those
8 employees are not compensated according to the number of
9 farmworkers they recruit.

10 (10) Privately-operated job recruitment centers.

11 (11) Massage establishments. As used in this Act,
12 "massage establishment" means a place of business in which
13 any method of massage therapy is administered or practiced
14 for compensation. "Massage establishment" does not
15 include: an establishment at which persons licensed under
16 the Medical Practice Act of 1987, the Illinois Physical
17 Therapy Act, or the Naprapathic Practice Act engage in
18 practice under one of those Acts; a business owned by a
19 sole licensed massage therapist; or a cosmetology or
20 esthetics salon registered under the Barber, Cosmetology,
21 Esthetics, Hair Braiding, and Nail Technology Act of 1985.

22 (b) The Department of Transportation shall, upon the
23 availability of the model notice described in Section 15 of
24 this Act, post a notice that complies with the requirements of
25 this Act in a conspicuous place near the public entrance of
26 each roadside rest area or in another conspicuous location in

1 clear view of the public and employees where similar notices
2 are customarily posted.

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

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

16 (e) The administrator of a public or private elementary
17 school or public or private secondary school shall post a
18 printout of the downloadable notice provided by the Department
19 of Human Services under Section 15 that complies with the
20 requirements of this Act in a conspicuous and accessible place
21 chosen by the administrator in the administrative office or
22 another location in view of school employees. School districts
23 and personnel are not subject to the penalties provided under
24 subsection (a) of Section 20.

25 (f) The owner of an establishment registered under the
26 Tattoo and Body Piercing Establishment Registration Act shall

1 post a notice that complies with the requirements of this Act
2 in a conspicuous and accessible place in clear view of
3 establishment employees.

4 (Source: P.A. 99-99, eff. 1-1-16; 99-565, eff. 7-1-17;
5 100-671, eff. 1-1-19.)

6 (775 ILCS 50/10)

7 Sec. 10. Form of posted notice.

8 (a) The notice required under this Act shall be at least 8
9 1/2 inches by 11 inches in size, written in a 16-point font,
10 except that when the notice is provided by electronic means
11 the size of the notice and font shall not be required to comply
12 with these specifications, and shall state the following:

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

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

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

22 * Toll-free.

23 * Operated by nonprofit nongovernmental organizations.

1 * Anonymous and confidential.

2 * Accessible in more than 160 languages.

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

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

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

15 Article 20.

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

18 (110 ILCS 330/8d new)

19 Sec. 8d. N95 masks. Pursuant to and in accordance with
20 applicable local, State, and federal policies, guidance and
21 recommendations of public health and infection control
22 authorities, and taking into consideration the limitations on

1 access to N95 masks caused by disruptions in local, State,
2 national, and international supply chains, the University of
3 Illinois Hospital shall provide N95 masks to physicians
4 licensed under the Medical Practice Act of 1987, registered
5 nurses and advanced practice registered nurses licensed under
6 the Nurse Licensing Act, and any other employees or
7 contractual workers who provide direct patient care and who,
8 pursuant to such policies, guidance, and recommendations, are
9 recommended to have such a mask to safely provide such direct
10 patient care within a hospital setting. Nothing in this
11 Section shall be construed to impose any new duty or
12 obligation on the University of Illinois Hospital or employee
13 that is greater than that imposed under State and federal laws
14 in effect on the effective date of this amendatory Act of the
15 102nd General Assembly. This Section is repealed on December
16 31, 2021.

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

19 (210 ILCS 85/6.28 new)

20 Sec. 6.28. N95 masks. Pursuant to and in accordance with
21 applicable local, State, and federal policies, guidance and
22 recommendations of public health and infection control
23 authorities, and taking into consideration the limitations on
24 access to N95 masks caused by disruptions in local, State,

1 national, and international supply chains, a hospital licensed
2 under this Act shall provide N95 masks to physicians licensed
3 under the Medical Practice Act of 1987, registered nurses and
4 advanced practice registered nurses licensed under the Nurse
5 Licensing Act, and any other employees or contractual workers
6 who provide direct patient care and who, pursuant to such
7 policies, guidance, and recommendations, are recommended to
8 have such a mask to safely provide such direct patient care
9 within a hospital setting. Nothing in this Section shall be
10 construed to impose any new duty or obligation on the hospital
11 or employee that is greater than that imposed under State and
12 federal laws in effect on the effective date of this
13 amendatory Act of the 102nd General Assembly. This Section is
14 repealed on December 31, 2021.

15 Article 35.

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

18 (305 ILCS 5/5-5.05)

19 Sec. 5-5.05. Hospitals; psychiatric services.

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

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

1 following:

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

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

4 (3) BroMenn Healthcare, Bloomington, Illinois.

5 (4) Jackson Park Hospital, Chicago, Illinois.

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

7 (6) Lawrence County Memorial Hospital, Lawrenceville,
8 Illinois.

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

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

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

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

17 (11) Rockford Memorial Hospital, Rockford, Illinois.

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

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

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

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

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

- 1 (17) St. Mary of Nazareth Hospital, Chicago, Illinois.
- 2 (18) Provena St. Mary's Hospital, Kankakee, Illinois.
- 3 (19) St. Mary's Hospital, Decatur, Illinois.
- 4 (20) Memorial Hospital, Belleville, Illinois.
- 5 (21) Swedish Covenant Hospital, Chicago, Illinois.
- 6 (22) Trinity Medical Center, Rock Island, Illinois.
- 7 (23) St. Elizabeth Hospital, Chicago, Illinois.
- 8 (24) Richland Memorial Hospital, Olney, Illinois.
- 9 (25) St. Elizabeth's Hospital, Belleville, Illinois.
- 10 (26) Samaritan Health System, Clinton, Iowa.
- 11 (27) St. John's Hospital, Springfield, Illinois.
- 12 (28) St. Mary's Hospital, Centralia, Illinois.
- 13 (29) Loretto Hospital, Chicago, Illinois.
- 14 (30) Kenneth Hall Regional Hospital, East St. Louis,
15 Illinois.
- 16 (31) Hinsdale Hospital, Hinsdale, Illinois.
- 17 (32) Pekin Hospital, Pekin, Illinois.
- 18 (33) University of Chicago Medical Center, Chicago,
19 Illinois.
- 20 (34) St. Anthony's Health Center, Alton, Illinois.
- 21 (35) OSF St. Francis Medical Center, Peoria, Illinois.
- 22 (36) Memorial Medical Center, Springfield, Illinois.
- 23 (37) A hospital with a distinct part unit for
24 psychiatric services that begins operating on or after
25 July 1, 2008.
- 26 For purposes of this Section, "inpatient psychiatric

1 services" means those services provided to patients who are in
2 need of short-term acute inpatient hospitalization for active
3 treatment of an emotional or mental disorder.

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

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

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

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

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

23 Title IV. Medical Implicit Bias

24 Article 45.

1 Section 45-5. The Department of Professional Regulation
2 Law of the Civil Administrative Code of Illinois is amended by
3 adding Section 2105-15.7 as follows:

4 (20 ILCS 2105/2105-15.7 new)

5 Sec. 2105-15.7. Implicit bias awareness training.

6 (a) As used in this Section, "health care professional"
7 means a person licensed or registered by the Department of
8 Financial and Professional Regulation under the following
9 Acts: Medical Practice Act of 1987, Nurse Practice Act,
10 Clinical Psychologist Licensing Act, Illinois Dental Practice
11 Act, Illinois Optometric Practice Act of 1987, Pharmacy
12 Practice Act, Illinois Physical Therapy Act, Physician
13 Assistant Practice Act of 1987, Acupuncture Practice Act,
14 Illinois Athletic Trainers Practice Act, Clinical Social Work
15 and Social Work Practice Act, Dietitian Nutritionist Practice
16 Act, Home Medical Equipment and Services Provider License Act,
17 Naprapathic Practice Act, Nursing Home Administrators
18 Licensing and Disciplinary Act, Illinois Occupational Therapy
19 Practice Act, Illinois Optometric Practice Act of 1987,
20 Podiatric Medical Practice Act of 1987, Respiratory Care
21 Practice Act, Professional Counselor and Clinical Professional
22 Counselor Licensing and Practice Act, Sex Offender Evaluation
23 and Treatment Provider Act, Illinois Speech-Language Pathology
24 and Audiology Practice Act, Perfusionist Practice Act,

1 Registered Surgical Assistant and Registered Surgical
2 Technologist Title Protection Act, and Genetic Counselor
3 Licensing Act.

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

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

18 Title V. Substance Abuse and Mental Health Treatment

19 Article 50.

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

22 (720 ILCS 570/414)

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

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

8 (b) A person who, in good faith, seeks or obtains
9 emergency medical assistance for someone experiencing an
10 overdose shall not be arrested, charged, or prosecuted for a
11 violation of Section 401 or 402 of the Illinois Controlled
12 Substances Act, Section 3.5 of the Drug Paraphernalia Control
13 Act, Section 55 or 60 of the Methamphetamine Control and
14 Community Protection Act, Section 9-3.3 of the Criminal Code
15 of 2012, or paragraph (1) of subsection (g) of Section 12-3.05
16 of the Criminal Code of 2012 ~~Class 4 felony possession of a~~
17 ~~controlled, counterfeit, or look-alike substance or a~~
18 ~~controlled substance analog~~ if evidence for the violation
19 ~~Class 4 felony possession charge~~ was acquired as a result of
20 the person seeking or obtaining emergency medical assistance
21 and providing the amount of substance recovered is within the
22 amount identified in subsection (d) of this Section. The
23 violations listed in this subsection (b) must not serve as the
24 sole basis of a violation of parole, mandatory supervised
25 release, probation, or conditional discharge, or any seizure
26 of property under any State law authorizing civil forfeiture

1 so long as the evidence for the violation was acquired as a
2 result of the person seeking or obtaining emergency medical
3 assistance in the event of an overdose.

4 (c) A person who is experiencing an overdose shall not be
5 arrested, charged, or prosecuted for a violation of Section
6 401 or 402 of the Illinois Controlled Substances Act, Section
7 3.5 of the Drug Paraphernalia Control Act, Section 9-3.3 of
8 the Criminal Code of 2012, or paragraph (1) of subsection (g)
9 of Section 12-3.05 of the Criminal Code of 2012 ~~Class 4 felony~~
10 ~~possession of a controlled, counterfeit, or look alike~~
11 ~~substance or a controlled substance analog~~ if evidence for the
12 violation ~~Class 4 felony possession charge~~ was acquired as a
13 result of the person seeking or obtaining emergency medical
14 assistance and providing the amount of substance recovered is
15 within the amount identified in subsection (d) of this
16 Section. The violations listed in this subsection (c) must not
17 serve as the sole basis of a violation of parole, mandatory
18 supervised release, probation, or conditional discharge, or
19 any seizure of property under any State law authorizing civil
20 forfeiture so long as the evidence for the violation was
21 acquired as a result of the person seeking or obtaining
22 emergency medical assistance in the event of an overdose.

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

26 (1) less than 3 grams of a substance containing

1 heroin;

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

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

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

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

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

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

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

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

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

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

1 of ketamine;

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

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

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

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

1 (720 ILCS 646/115)

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

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

8 (b) A person who, in good faith, seeks emergency medical
9 assistance for someone experiencing an overdose shall not be
10 arrested, charged or prosecuted for a violation of Section 55
11 or 60 of this Act or Section 3.5 of the Drug Paraphernalia
12 Control Act, Section 9-3.3 of the Criminal Code of 2012, or
13 paragraph (1) of subsection (g) of Section 12-3.05 of the
14 Criminal Code of 2012 ~~Class 3 felony possession of~~
15 ~~methamphetamine~~ if evidence for the violation ~~Class 3 felony~~
16 ~~possession charge~~ was acquired as a result of the person
17 seeking or obtaining emergency medical assistance and
18 providing the amount of substance recovered is less than 3
19 grams ~~one gram~~ of methamphetamine or a substance containing
20 methamphetamine. The violations listed in this subsection (b)
21 must not serve as the sole basis of a violation of parole,
22 mandatory supervised release, probation, or conditional
23 discharge, or any seizure of property under any State law
24 authorizing civil forfeiture so long as the evidence for the
25 violation was acquired as a result of the person seeking or

1 obtaining emergency medical assistance in the event of an
2 overdose.

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

21 (d) The limited immunity described in subsections (b) and
22 (c) of this Section shall not be extended if law enforcement
23 has reasonable suspicion or probable cause to detain, arrest,
24 or search the person described in subsection (b) or (c) of this
25 Section for criminal activity and the reasonable suspicion or
26 probable cause is based on information obtained prior to or

1 independent of the individual described in subsection (b) or
2 (c) taking action to seek or obtain emergency medical
3 assistance and not obtained as a direct result of the action of
4 seeking or obtaining emergency medical assistance. Nothing in
5 this Section is intended to interfere with or prevent the
6 investigation, arrest, or prosecution of any person for the
7 delivery or distribution of cannabis, methamphetamine or other
8 controlled substances, drug-induced homicide, or any other
9 crime if the evidence of the violation is not acquired as a
10 result of the person seeking or obtaining emergency medical
11 assistance in the event of an overdose.

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

13 Article 60.

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

16 (320 ILCS 20/3.1 new)

17 Sec. 3.1. Adult protective services dementia training.

18 (a) This Section shall apply to any person who is employed
19 by the Department in the Adult Protective Services division,
20 or is contracted with the Department, and works on the
21 development or implementation of social services to respond to
22 and prevent adult abuse, neglect, or exploitation.

23 (b) The Department shall implement a dementia training

1 program that must include instruction on the identification of
2 people with dementia, risks such as wandering, communication
3 impairments, and elder abuse, and the best practices for
4 interacting with people with dementia.

5 (c) Training of at least 2 hours shall be completed at the
6 start of employment with the Adult Protective Services
7 division. Persons who are employees of the Adult Protective
8 Services division on the effective date of this amendatory Act
9 of the 102nd General Assembly shall complete this training
10 within 6 months after the effective date of this amendatory
11 Act of the 102nd General Assembly. The training shall cover
12 the following subjects:

13 (1) Alzheimer's disease and dementia.

14 (2) Safety risks.

15 (3) Communication and behavior.

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

19 (e) This Section is designed to address gaps in current
20 dementia training requirements for Adult Protective Services
21 officials and improve the quality of training. If laws or
22 rules existing on the effective date of this amendatory Act of
23 the 102nd General Assembly contain more rigorous training
24 requirements for Adult Protective Service officials, those
25 laws or rules shall apply. Where there is overlap between this
26 Section and other laws and rules, the Department shall

1 interpret this Section to avoid duplication of requirements
2 while ensuring that the minimum requirements set in this
3 Section are met.

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

6 Article 65.

7 Section 65-1. Short title. This Article may be cited as
8 the Behavioral Health Workforce Education Center of Illinois
9 Act. References in this Article to "this Act" mean this
10 Article.

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

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

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

20 (3) In 2019, the Journal of Community Health found
21 that suicide rates are disproportionately higher among
22 African American adolescents. From 2001 to 2017, the rate
23 for African American teen boys rose 60%, according to the

1 study. Among African American teen girls, rates nearly
2 tripled, rising by an astounding 182%. Illinois was among
3 the 10 states with the greatest number of African American
4 adolescent suicides (2015-2017).

5 (4) Workforce shortages are evident in all behavioral
6 health professions, including, but not limited to,
7 psychiatry, psychiatric nursing, psychiatric physician
8 assistant, social work (licensed social work, licensed
9 clinical social work), counseling (licensed professional
10 counseling, licensed clinical professional counseling),
11 marriage and family therapy, licensed clinical psychology,
12 occupational therapy, prevention, substance use disorder
13 counseling, and peer support.

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

22 (6) Estimates of unmet needs consistently highlight
23 the dire situation in Illinois. Mental Health America
24 ranks Illinois 29th in the country in mental health
25 workforce availability based on its 480-to-1 ratio of
26 population to mental health professionals, and the Kaiser

1 Family Foundation estimates that only 23.3% of
2 Illinoisans' mental health needs can be met with its
3 current workforce.

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

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

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

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

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

4 (12) According to the Statewide Semiannual Opioid
5 Report, Illinois Department of Public Health, September
6 2020, the number of opioid deaths in Illinois has
7 increased 3% from 2,167 deaths in 2018 to 2,233 deaths in
8 2019.

9 (13) Behavioral health workforce shortages have led to
10 well-documented problems of long wait times for
11 appointments with psychiatrists (4 to 6 months in some
12 cases), high turnover, and unfilled vacancies for social
13 workers and other behavioral health professionals that
14 have eroded the gains in insurance coverage for mental
15 illness and substance use disorder under the federal
16 Affordable Care Act and parity laws.

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

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

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

9 (17) This State has a compelling and substantial
10 interest in building a pipeline for behavioral health
11 professionals and to anchor research and education for
12 behavioral health workforce development. Beginning with
13 the proposed Behavioral Health Workforce Education Center
14 of Illinois, Illinois has the chance to develop a
15 blueprint to be a national leader in behavioral health
16 workforce development.

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

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

23 (a) The Behavioral Health Workforce Education Center of
24 Illinois is created and shall be administered by a teaching,
25 research, or both teaching and research public institution of

1 higher education in this State. Subject to appropriation, the
2 Center shall be operational on or before July 1, 2022.

3 (b) The Behavioral Health Workforce Education Center of
4 Illinois shall leverage workforce and behavioral health
5 resources, including, but not limited to, State, federal, and
6 foundation grant funding, federal Workforce Investment Act of
7 1998 programs, the National Health Service Corps and other
8 nongraduate medical education physician workforce training
9 programs, and existing behavioral health partnerships, and
10 align with reforms in Illinois.

11 Section 65-15. Structure.

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

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

25 (c) The Behavioral Health Workforce Education Center of

1 Illinois shall also coordinate with key State agencies
2 involved in behavioral health, workforce development, and
3 higher education in order to leverage disparate resources from
4 health care, workforce, and economic development programs in
5 Illinois government.

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

9 (1) Organize a consortium of universities in
10 partnerships with providers, school districts, law
11 enforcement, consumers and their families, State agencies,
12 and other stakeholders to implement workforce development
13 concepts and strategies in every region of this State.

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

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

25 (B) collecting and analyzing data on the

1 behavioral health workforce in Illinois, with detailed
2 information on specialties, credentials, additional
3 qualifications (such as training or experience in
4 particular models of care), location of practice, and
5 demographic characteristics, including age, gender,
6 race and ethnicity, and languages spoken;

7 (C) building partnerships with school districts,
8 public institutions of higher education, and workforce
9 investment agencies to create pipelines to behavioral
10 health careers from high schools and colleges,
11 pathways to behavioral health specialization among
12 health professional students, and expanded behavioral
13 health residency and internship opportunities for
14 graduates;

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

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

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

26 (3) Coordinate data collection and analysis, including

1 systematic tracking of the behavioral health workforce and
2 datasets that support workforce planning for an
3 accessible, high-quality behavioral health system. In the
4 medium to long-term, the Center shall develop Illinois
5 behavioral workforce data capacity by:

6 (A) filling gaps in workforce data by collecting
7 information on specialty, training, and qualifications
8 for specific models of care, demographic
9 characteristics, including gender, race, ethnicity,
10 and languages spoken, and participation in public and
11 private insurance networks;

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

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

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

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

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

25 (B) evaluating available peer-parent training
26 models, choosing a model that meets Illinois' needs,

1 and working with partners to implement it universally
2 in child-serving programs throughout this State; and

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

6 (5) Focus on the training of behavioral health
7 professionals in telehealth techniques, including taking
8 advantage of a telehealth network that exists, and other
9 innovative means of care delivery in order to increase
10 access to behavioral health services for all persons
11 within this State.

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

19 Section 65-25. Selection process.

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

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

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

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

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

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

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

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

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

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

1 learning equipment.

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

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

10 Title VI. Access to Health Care

11 Article 70.

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

14 (35 ILCS 105/3-10)

15 Sec. 3-10. Rate of tax. Unless otherwise provided in this
16 Section, the tax imposed by this Act is at the rate of 6.25% of
17 either the selling price or the fair market value, if any, of
18 the tangible personal property. In all cases where property
19 functionally used or consumed is the same as the property that
20 was purchased at retail, then the tax is imposed on the selling
21 price of the property. In all cases where property
22 functionally used or consumed is a by-product or waste product

1 that has been refined, manufactured, or produced from property
2 purchased at retail, then the tax is imposed on the lower of
3 the fair market value, if any, of the specific property so used
4 in this State or on the selling price of the property purchased
5 at retail. For purposes of this Section "fair market value"
6 means the price at which property would change hands between a
7 willing buyer and a willing seller, neither being under any
8 compulsion to buy or sell and both having reasonable knowledge
9 of the relevant facts. The fair market value shall be
10 established by Illinois sales by the taxpayer of the same
11 property as that functionally used or consumed, or if there
12 are no such sales by the taxpayer, then comparable sales or
13 purchases of property of like kind and character in Illinois.

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

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

21 With respect to gasohol, the tax imposed by this Act
22 applies to (i) 70% of the proceeds of sales made on or after
23 January 1, 1990, and before July 1, 2003, (ii) 80% of the
24 proceeds of sales made on or after July 1, 2003 and on or
25 before July 1, 2017, and (iii) 100% of the proceeds of sales
26 made thereafter. If, at any time, however, the tax under this

1 Act on sales of gasohol is imposed at the rate of 1.25%, then
2 the tax imposed by this Act applies to 100% of the proceeds of
3 sales of gasohol made during that time.

4 With respect to majority blended ethanol fuel, the tax
5 imposed by this Act does not apply to the proceeds of sales
6 made on or after July 1, 2003 and on or before December 31,
7 2023 but applies to 100% of the proceeds of sales made
8 thereafter.

9 With respect to biodiesel blends with no less than 1% and
10 no more than 10% biodiesel, the tax imposed by this Act applies
11 to (i) 80% of the proceeds of sales made on or after July 1,
12 2003 and on or before December 31, 2018 and (ii) 100% of the
13 proceeds of sales made thereafter. If, at any time, however,
14 the tax under this Act on sales of biodiesel blends with no
15 less than 1% and no more than 10% biodiesel is imposed at the
16 rate of 1.25%, then the tax imposed by this Act applies to 100%
17 of the proceeds of sales of biodiesel blends with no less than
18 1% and no more than 10% biodiesel made during that time.

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

24 With respect to food for human consumption that is to be
25 consumed off the premises where it is sold (other than
26 alcoholic beverages, food consisting of or infused with adult

1 use cannabis, soft drinks, and food that has been prepared for
2 immediate consumption) and prescription and nonprescription
3 medicines, drugs, medical appliances, products classified as
4 Class III medical devices by the United States Food and Drug
5 Administration that are used for cancer treatment pursuant to
6 a prescription, as well as any accessories and components
7 related to those devices, modifications to a motor vehicle for
8 the purpose of rendering it usable by a person with a
9 disability, and insulin, blood sugar ~~urine~~ testing materials,
10 syringes, and needles used by human diabetics, ~~for human use,~~
11 the tax is imposed at the rate of 1%. For the purposes of this
12 Section, until September 1, 2009: the term "soft drinks" means
13 any complete, finished, ready-to-use, non-alcoholic drink,
14 whether carbonated or not, including but not limited to soda
15 water, cola, fruit juice, vegetable juice, carbonated water,
16 and all other preparations commonly known as soft drinks of
17 whatever kind or description that are contained in any closed
18 or sealed bottle, can, carton, or container, regardless of
19 size; but "soft drinks" does not include coffee, tea,
20 non-carbonated water, infant formula, milk or milk products as
21 defined in the Grade A Pasteurized Milk and Milk Products Act,
22 or drinks containing 50% or more natural fruit or vegetable
23 juice.

24 Notwithstanding any other provisions of this Act,
25 beginning September 1, 2009, "soft drinks" means non-alcoholic
26 beverages that contain natural or artificial sweeteners. "Soft

1 drinks" do not include beverages that contain milk or milk
2 products, soy, rice or similar milk substitutes, or greater
3 than 50% of vegetable or fruit juice by volume.

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

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

25 Notwithstanding any other provisions of this Act,
26 beginning September 1, 2009, "nonprescription medicines and

1 drugs" does not include grooming and hygiene products. For
2 purposes of this Section, "grooming and hygiene products"
3 includes, but is not limited to, soaps and cleaning solutions,
4 shampoo, toothpaste, mouthwash, antiperspirants, and sun tan
5 lotions and screens, unless those products are available by
6 prescription only, regardless of whether the products meet the
7 definition of "over-the-counter-drugs". For the purposes of
8 this paragraph, "over-the-counter-drug" means a drug for human
9 use that contains a label that identifies the product as a drug
10 as required by 21 C.F.R. § 201.66. The "over-the-counter-drug"
11 label includes:

12 (A) A "Drug Facts" panel; or

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

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

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

26 If the property that is purchased at retail from a

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

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

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

11 (35 ILCS 110/3-10) (from Ch. 120, par. 439.33-10)

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

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

22 With respect to gasohol, as defined in the Use Tax Act, the
23 tax imposed by this Act applies to (i) 70% of the selling price
24 of property transferred as an incident to the sale of service

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

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

15 With respect to biodiesel blends, as defined in the Use
16 Tax Act, with no less than 1% and no more than 10% biodiesel,
17 the tax imposed by this Act applies to (i) 80% of the selling
18 price of property transferred as an incident to the sale of
19 service on or after July 1, 2003 and on or before December 31,
20 2018 and (ii) 100% of the proceeds of the selling price
21 thereafter. If, at any time, however, the tax under this Act on
22 sales of biodiesel blends, as defined in the Use Tax Act, with
23 no less than 1% and no more than 10% biodiesel is imposed at
24 the rate of 1.25%, then the tax imposed by this Act applies to
25 100% of the proceeds of sales of biodiesel blends with no less
26 than 1% and no more than 10% biodiesel made during that time.

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

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

18 The tax shall be imposed at the rate of 1% on food prepared
19 for immediate consumption and transferred incident to a sale
20 of service subject to this Act or the Service Occupation Tax
21 Act by an entity licensed under the Hospital Licensing Act,
22 the Nursing Home Care Act, the ID/DD Community Care Act, the
23 MC/DD Act, the Specialized Mental Health Rehabilitation Act of
24 2013, or the Child Care Act of 1969. The tax shall also be
25 imposed at the rate of 1% on food for human consumption that is
26 to be consumed off the premises where it is sold (other than

1 alcoholic beverages, food consisting of or infused with adult
2 use cannabis, soft drinks, and food that has been prepared for
3 immediate consumption and is not otherwise included in this
4 paragraph) and prescription and nonprescription medicines,
5 drugs, medical appliances, products classified as Class III
6 medical devices by the United States Food and Drug
7 Administration that are used for cancer treatment pursuant to
8 a prescription, as well as any accessories and components
9 related to those devices, modifications to a motor vehicle for
10 the purpose of rendering it usable by a person with a
11 disability, and insulin, blood sugar ~~urine~~ testing materials,
12 syringes, and needles used by human diabetics, ~~for human use~~.
13 For the purposes of this Section, until September 1, 2009: the
14 term "soft drinks" means any complete, finished, ready-to-use,
15 non-alcoholic drink, whether carbonated or not, including but
16 not limited to soda water, cola, fruit juice, vegetable juice,
17 carbonated water, and all other preparations commonly known as
18 soft drinks of whatever kind or description that are contained
19 in any closed or sealed bottle, can, carton, or container,
20 regardless of size; but "soft drinks" does not include coffee,
21 tea, non-carbonated water, infant formula, milk or milk
22 products as defined in the Grade A Pasteurized Milk and Milk
23 Products Act, or drinks containing 50% or more natural fruit
24 or vegetable juice.

25 Notwithstanding any other provisions of this Act,
26 beginning September 1, 2009, "soft drinks" means non-alcoholic

1 beverages that contain natural or artificial sweeteners. "Soft
2 drinks" do not include beverages that contain milk or milk
3 products, soy, rice or similar milk substitutes, or greater
4 than 50% of vegetable or fruit juice by volume.

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

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

26 Notwithstanding any other provisions of this Act,

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

13 (A) A "Drug Facts" panel; or

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

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

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

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

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

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

12 (35 ILCS 115/3-10) (from Ch. 120, par. 439.103-10)

13 Sec. 3-10. Rate of tax. Unless otherwise provided in this
14 Section, the tax imposed by this Act is at the rate of 6.25% of
15 the "selling price", as defined in Section 2 of the Service Use
16 Tax Act, of the tangible personal property. For the purpose of
17 computing this tax, in no event shall the "selling price" be
18 less than the cost price to the serviceman of the tangible
19 personal property transferred. The selling price of each item
20 of tangible personal property transferred as an incident of a
21 sale of service may be shown as a distinct and separate item on
22 the serviceman's billing to the service customer. If the
23 selling price is not so shown, the selling price of the
24 tangible personal property is deemed to be 50% of the

1 serviceman's entire billing to the service customer. When,
2 however, a serviceman contracts to design, develop, and
3 produce special order machinery or equipment, the tax imposed
4 by this Act shall be based on the serviceman's cost price of
5 the tangible personal property transferred incident to the
6 completion of the contract.

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

11 With respect to gasohol, as defined in the Use Tax Act, the
12 tax imposed by this Act shall apply to (i) 70% of the cost
13 price of property transferred as an incident to the sale of
14 service on or after January 1, 1990, and before July 1, 2003,
15 (ii) 80% of the selling price of property transferred as an
16 incident to the sale of service on or after July 1, 2003 and on
17 or before July 1, 2017, and (iii) 100% of the cost price
18 thereafter. If, at any time, however, the tax under this Act on
19 sales of gasohol, as defined in the Use Tax Act, is imposed at
20 the rate of 1.25%, then the tax imposed by this Act applies to
21 100% of the proceeds of sales of gasohol made during that time.

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

1 thereafter.

2 With respect to biodiesel blends, as defined in the Use
3 Tax Act, with no less than 1% and no more than 10% biodiesel,
4 the tax imposed by this Act applies to (i) 80% of the selling
5 price of property transferred as an incident to the sale of
6 service on or after July 1, 2003 and on or before December 31,
7 2018 and (ii) 100% of the proceeds of the selling price
8 thereafter. If, at any time, however, the tax under this Act on
9 sales of biodiesel blends, as defined in the Use Tax Act, with
10 no less than 1% and no more than 10% biodiesel is imposed at
11 the rate of 1.25%, then the tax imposed by this Act applies to
12 100% of the proceeds of sales of biodiesel blends with no less
13 than 1% and no more than 10% biodiesel made during that time.

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

22 At the election of any registered serviceman made for each
23 fiscal year, sales of service in which the aggregate annual
24 cost price of tangible personal property transferred as an
25 incident to the sales of service is less than 35%, or 75% in
26 the case of servicemen transferring prescription drugs or

1 servicemen engaged in graphic arts production, of the
2 aggregate annual total gross receipts from all sales of
3 service, the tax imposed by this Act shall be based on the
4 serviceman's cost price of the tangible personal property
5 transferred incident to the sale of those services.

6 The tax shall be imposed at the rate of 1% on food prepared
7 for immediate consumption and transferred incident to a sale
8 of service subject to this Act or the Service Occupation Tax
9 Act by an entity licensed under the Hospital Licensing Act,
10 the Nursing Home Care Act, the ID/DD Community Care Act, the
11 MC/DD Act, the Specialized Mental Health Rehabilitation Act of
12 2013, or the Child Care Act of 1969. The tax shall also be
13 imposed at the rate of 1% on food for human consumption that is
14 to be consumed off the premises where it is sold (other than
15 alcoholic beverages, food consisting of or infused with adult
16 use cannabis, soft drinks, and food that has been prepared for
17 immediate consumption and is not otherwise included in this
18 paragraph) and prescription and nonprescription medicines,
19 drugs, medical appliances, products classified as Class III
20 medical devices by the United States Food and Drug
21 Administration that are used for cancer treatment pursuant to
22 a prescription, as well as any accessories and components
23 related to those devices, modifications to a motor vehicle for
24 the purpose of rendering it usable by a person with a
25 disability, and insulin, blood sugar ~~urine~~ testing materials,
26 syringes, and needles used by human diabetics, ~~for human use.~~

1 For the purposes of this Section, until September 1, 2009: the
2 term "soft drinks" means any complete, finished, ready-to-use,
3 non-alcoholic drink, whether carbonated or not, including but
4 not limited to soda water, cola, fruit juice, vegetable juice,
5 carbonated water, and all other preparations commonly known as
6 soft drinks of whatever kind or description that are contained
7 in any closed or sealed can, carton, or container, regardless
8 of size; but "soft drinks" does not include coffee, tea,
9 non-carbonated water, infant formula, milk or milk products as
10 defined in the Grade A Pasteurized Milk and Milk Products Act,
11 or drinks containing 50% or more natural fruit or vegetable
12 juice.

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

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

1 off the premises where it is sold" includes all food sold
2 through a vending machine, except soft drinks, candy, and food
3 products that are dispensed hot from a vending machine,
4 regardless of the location of the vending machine.

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

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

1 (A) A "Drug Facts" panel; or

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

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

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

15 (Source: P.A. 100-22, eff. 7-6-17; 101-363, eff. 8-9-19;
16 101-593, eff. 12-4-19.)

17 Section 70-20. The Retailers' Occupation Tax Act is
18 amended by changing Section 2-10 as follows:

19 (35 ILCS 120/2-10)

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

24 Beginning on July 1, 2000 and through December 31, 2000,

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

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

7 Within 14 days after the effective date of this amendatory
8 Act of the 91st General Assembly, each retailer of motor fuel
9 and gasohol shall cause the following notice to be posted in a
10 prominently visible place on each retail dispensing device
11 that is used to dispense motor fuel or gasohol in the State of
12 Illinois: "As of July 1, 2000, the State of Illinois has
13 eliminated the State's share of sales tax on motor fuel and
14 gasohol through December 31, 2000. The price on this pump
15 should reflect the elimination of the tax." The notice shall
16 be printed in bold print on a sign that is no smaller than 4
17 inches by 8 inches. The sign shall be clearly visible to
18 customers. Any retailer who fails to post or maintain a
19 required sign through December 31, 2000 is guilty of a petty
20 offense for which the fine shall be \$500 per day per each
21 retail premises where a violation occurs.

22 With respect to gasohol, as defined in the Use Tax Act, the
23 tax imposed by this Act applies to (i) 70% of the proceeds of
24 sales made on or after January 1, 1990, and before July 1,
25 2003, (ii) 80% of the proceeds of sales made on or after July
26 1, 2003 and on or before July 1, 2017, and (iii) 100% of the

1 proceeds of sales made thereafter. If, at any time, however,
2 the tax under this Act on sales of gasohol, as defined in the
3 Use Tax Act, is imposed at the rate of 1.25%, then the tax
4 imposed by this Act applies to 100% of the proceeds of sales of
5 gasohol made during that time.

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

11 With respect to biodiesel blends, as defined in the Use
12 Tax Act, with no less than 1% and no more than 10% biodiesel,
13 the tax imposed by this Act applies to (i) 80% of the proceeds
14 of sales made on or after July 1, 2003 and on or before
15 December 31, 2018 and (ii) 100% of the proceeds of sales made
16 thereafter. If, at any time, however, the tax under this Act on
17 sales of biodiesel blends, as defined in the Use Tax Act, with
18 no less than 1% and no more than 10% biodiesel is imposed at
19 the rate of 1.25%, then the tax imposed by this Act applies to
20 100% of the proceeds of sales of biodiesel blends with no less
21 than 1% and no more than 10% biodiesel made during that time.

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

1 applies to 100% of the proceeds of sales made thereafter.

2 With respect to food for human consumption that is to be
3 consumed off the premises where it is sold (other than
4 alcoholic beverages, food consisting of or infused with adult
5 use cannabis, soft drinks, and food that has been prepared for
6 immediate consumption) and prescription and nonprescription
7 medicines, drugs, medical appliances, products classified as
8 Class III medical devices by the United States Food and Drug
9 Administration that are used for cancer treatment pursuant to
10 a prescription, as well as any accessories and components
11 related to those devices, modifications to a motor vehicle for
12 the purpose of rendering it usable by a person with a
13 disability, and insulin, blood sugar ~~urine~~ testing materials,
14 syringes, and needles used by human diabetics, ~~for human use,~~
15 the tax is imposed at the rate of 1%. For the purposes of this
16 Section, until September 1, 2009: the term "soft drinks" means
17 any complete, finished, ready-to-use, non-alcoholic drink,
18 whether carbonated or not, including but not limited to soda
19 water, cola, fruit juice, vegetable juice, carbonated water,
20 and all other preparations commonly known as soft drinks of
21 whatever kind or description that are contained in any closed
22 or sealed bottle, can, carton, or container, regardless of
23 size; but "soft drinks" does not include coffee, tea,
24 non-carbonated water, infant formula, milk or milk products as
25 defined in the Grade A Pasteurized Milk and Milk Products Act,
26 or drinks containing 50% or more natural fruit or vegetable

1 juice.

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

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

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

1 pieces. "Candy" does not include any preparation that contains
2 flour or requires refrigeration.

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

16 (A) A "Drug Facts" panel; or

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

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

25 As used in this Section, "adult use cannabis" means
26 cannabis subject to tax under the Cannabis Cultivation

1 Privilege Tax Law and the Cannabis Purchaser Excise Tax Law
2 and does not include cannabis subject to tax under the
3 Compassionate Use of Medical Cannabis Program Act.
4 (Source: P.A. 100-22, eff. 7-6-17; 101-363, eff. 8-9-19;
5 101-593, eff. 12-4-19.)

6 Article 72.

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

9 Section 72-5. Legislative findings. In the State of
10 Illinois, two-thirds of gun violence is related to suicide,
11 and one-third is related to homicide, claiming approximately
12 12,000 lives a year. Violence has plagued communities,
13 predominantly poor and distressed communities in urban
14 settings, which have always treated violence as a criminal
15 justice issue, instead of a public health issue. On February
16 21, 2018, Pastor Anthony Williams was informed that his son,
17 Nehemiah William, had been shot to death. Due to this
18 disheartening event, Pastor Anthony Williams reached out to
19 State Representative Elizabeth "Lisa" Hernandez, urging that
20 the issue of violence be treated as a public health crisis. In
21 2018, elected officials from all levels of government started
22 a coalition to address violence as a public health crisis,
23 with the assistance of faith-based organizations, advocates,

1 and community members and held a statewide listening tour from
2 August 2018 to April 2019. The listening tour consisted of
3 stops on the South Side and West Side of Chicago, Maywood,
4 Springfield, and East St. Louis, with a future scheduled visit
5 in Danville. During the statewide listening sessions,
6 community members actively discussed neighborhood safety,
7 defining violence and how and why violence occurs in their
8 communities. The listening sessions provided different
9 solutions to address violence, however, all sessions confirmed
10 a disconnect from the priorities of government and the needs
11 of these communities.

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

19 Due to a variety of reasons, including in particular the
20 State's budget impasse, funds from multiple sources to
21 establish such a comprehensive policy are subject to
22 appropriation. Private philanthropic efforts will also be
23 considered. Policies like R3 are needed in order to provide
24 communities that have historically suffered from divestment,
25 poverty, and incarceration with smart solutions that can solve

1 the plague of structural violence that includes collective,
2 interpersonal, and self-directed violence. Understanding
3 structural violence helps explain the multiple and often
4 intersecting forces that create and perpetuate these
5 conditions on multiple levels. It is clear that violence is a
6 public health problem that needs to be treated as such.
7 Research has shown that when violence is treated in such a way
8 that educates, fosters collaboration, and redirects the
9 funding on a governmental level, its effects can be slowed or
10 even halted, resulting in civility being brought to our
11 communities in the State of Illinois. Research has shown that
12 when violence is treated in such a way, then its effects can be
13 slowed or even halted.

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

17 Article 80.

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

20 (820 ILCS 191/5)

21 Sec. 5. Definitions. In this Act:

22 "Covered family member" means an employee's child,

1 stepchild, spouse, domestic partner, sibling, parent,
2 mother-in-law, father-in-law, grandchild, grandparent, or
3 stepparent.

4 "Department" means the Department of Labor.

5 "Personal care" means activities to ensure that a covered
6 family member's basic medical, hygiene, nutritional, or safety
7 needs are met, or to provide transportation to medical
8 appointments, for a covered family member who is unable to
9 meet those needs himself or herself. "Personal care" also
10 means being physically present to provide emotional support to
11 a covered family member with a serious health condition who is
12 receiving inpatient or home care.

13 "Personal sick leave benefits" means any paid or unpaid
14 time available to an employee as provided through an
15 employment benefit plan or paid time off policy to be used as a
16 result of absence from work due to personal illness, injury,
17 ~~or~~ medical appointment, or for personal care of a covered
18 family member. An employment benefit plan or paid time off
19 policy does not include long term disability, short term
20 disability, an insurance policy, or other comparable benefit
21 plan or policy.

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

23 (820 ILCS 191/10)

24 Sec. 10. Use of leave; limitations.

25 (a) An employee may use personal sick leave benefits

1 provided by the employer for absences due to an illness,
2 injury, or medical appointment of the employee's child,
3 stepchild, spouse, domestic partner, sibling, parent,
4 mother-in-law, father-in-law, grandchild, grandparent, or
5 stepparent, or for personal care of a covered family member on
6 the same terms upon which the employee is able to use personal
7 sick leave benefits for the employee's own illness or injury.
8 An employer may request written verification of the employee's
9 absence from a health care professional if such verification
10 is required under the employer's employment benefit plan or
11 paid time off policy.

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

25 (c) An employer who provides personal sick leave benefits
26 or a paid time off policy that would otherwise provide

1 benefits as required under subsections (a) and (b) shall not
2 be required to modify such benefits.

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

4 Article 90.

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

7 (210 ILCS 45/3-206.06 new)

8 Sec. 3-206.06. Testing for Legionella bacteria. A facility
9 shall develop a policy for testing its water supply for
10 Legionella bacteria. The policy shall include the frequency
11 with which testing is conducted. The policy and the results of
12 any tests shall be made available to the Department upon
13 request.

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

16 (210 ILCS 85/6.29 new)

17 Sec. 6.29. Testing for Legionella bacteria. A hospital
18 shall develop a policy for testing its water supply for
19 Legionella bacteria. The policy shall include the frequency
20 with which testing is conducted. The policy and the results of
21 any tests shall be made available to the Department upon

1 request.

2 Article 95.

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

5 (225 ILCS 10/7) (from Ch. 23, par. 2217)

6 Sec. 7. (a) The Department must prescribe and publish
7 minimum standards for licensing that apply to the various
8 types of facilities for child care defined in this Act and that
9 are equally applicable to like institutions under the control
10 of the Department and to foster family homes used by and under
11 the direct supervision of the Department. The Department shall
12 seek the advice and assistance of persons representative of
13 the various types of child care facilities in establishing
14 such standards. The standards prescribed and published under
15 this Act take effect as provided in the Illinois
16 Administrative Procedure Act, and are restricted to
17 regulations pertaining to the following matters and to any
18 rules and regulations required or permitted by any other
19 Section of this Act:

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

22 (2) The character, suitability and qualifications of
23 the applicant and other persons directly responsible for

1 the care and welfare of children served. All child day
2 care center licensees and employees who are required to
3 report child abuse or neglect under the Abused and
4 Neglected Child Reporting Act shall be required to attend
5 training on recognizing child abuse and neglect, as
6 prescribed by Department rules;

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

10 (4) The number of individuals or staff required to
11 insure adequate supervision and care of the children
12 received. The standards shall provide that each child care
13 institution, maternity center, day care center, group
14 home, day care home, and group day care home shall have on
15 its premises during its hours of operation at least one
16 staff member certified in first aid, in the Heimlich
17 maneuver and in cardiopulmonary resuscitation by the
18 American Red Cross or other organization approved by rule
19 of the Department. Child welfare agencies shall not be
20 subject to such a staffing requirement. The Department may
21 offer, or arrange for the offering, on a periodic basis in
22 each community in this State in cooperation with the
23 American Red Cross, the American Heart Association or
24 other appropriate organization, voluntary programs to
25 train operators of foster family homes and day care homes
26 in first aid and cardiopulmonary resuscitation;

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

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

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

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

20 (9) Filing of reports with the Department;

21 (10) Discipline of children;

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

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

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

6 (14) Provisions requiring that any firearm permitted
7 on day care home premises, except handguns in the
8 possession of peace officers, shall be kept in a
9 disassembled state, without ammunition, in locked storage,
10 inaccessible to children and that ammunition permitted on
11 day care home premises shall be kept in locked storage
12 separate from that of disassembled firearms, inaccessible
13 to children;

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

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

25 (17) With respect to foster family homes, provisions
26 requiring the Department to review quality of care

1 concerns and to consider those concerns in determining
2 whether a foster family home is qualified to care for
3 children.

4 By July 1, 2022, all licensed day care home providers,
5 licensed group day care home providers, and licensed day care
6 center directors and classroom staff shall participate in at
7 least one training that includes the topics of early childhood
8 social emotional learning, infant and early childhood mental
9 health, early childhood trauma, or adverse childhood
10 experiences. Current licensed providers, directors, and
11 classroom staff shall complete training by July 1, 2022 and
12 shall participate in training that includes the above topics
13 at least once every 3 years.

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

23 (c) The Department shall investigate any person applying
24 to be licensed as a foster parent to determine whether there is
25 any evidence of current drug or alcohol abuse in the
26 prospective foster family. The Department shall not license a

1 person as a foster parent if drug or alcohol abuse has been
2 identified in the foster family or if a reasonable suspicion
3 of such abuse exists, except that the Department may grant a
4 foster parent license to an applicant identified with an
5 alcohol or drug problem if the applicant has successfully
6 participated in an alcohol or drug treatment program,
7 self-help group, or other suitable activities and if the
8 Department determines that the foster family home can provide
9 a safe, appropriate environment and meet the physical and
10 emotional needs of children.

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

22 (e) The Department shall distribute copies of licensing
23 standards to all licensees and applicants for a license. Each
24 licensee or holder of a permit shall distribute copies of the
25 appropriate licensing standards and any other information
26 required by the Department to child care facilities under its

1 supervision. Each licensee or holder of a permit shall
2 maintain appropriate documentation of the distribution of the
3 standards. Such documentation shall be part of the records of
4 the facility and subject to inspection by authorized
5 representatives of the Department.

6 (f) The Department shall prepare summaries of day care
7 licensing standards. Each licensee or holder of a permit for a
8 day care facility shall distribute a copy of the appropriate
9 summary and any other information required by the Department,
10 to the legal guardian of each child cared for in that facility
11 at the time when the child is enrolled or initially placed in
12 the facility. The licensee or holder of a permit for a day care
13 facility shall secure appropriate documentation of the
14 distribution of the summary and brochure. Such documentation
15 shall be a part of the records of the facility and subject to
16 inspection by an authorized representative of the Department.

17 (g) The Department shall distribute to each licensee and
18 holder of a permit copies of the licensing or permit standards
19 applicable to such person's facility. Each licensee or holder
20 of a permit shall make available by posting at all times in a
21 common or otherwise accessible area a complete and current set
22 of licensing standards in order that all employees of the
23 facility may have unrestricted access to such standards. All
24 employees of the facility shall have reviewed the standards
25 and any subsequent changes. Each licensee or holder of a
26 permit shall maintain appropriate documentation of the current

1 review of licensing standards by all employees. Such records
2 shall be part of the records of the facility and subject to
3 inspection by authorized representatives of the Department.

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

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

1 annually distributed to parents in August or September.

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

10 (Source: P.A. 99-143, eff. 7-27-15; 99-779, eff. 1-1-17;
11 100-201, eff. 8-18-17.)

12 Article 100.

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

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

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

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

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

23 (3) 20 members who shall be appointed as follows:

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

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

12 (C) three members appointed by the House
13 Minority Leader, one of whom shall be a survivor of
14 ovarian cancer, one of whom shall be a survivor of
15 cervical, vaginal, vulvar, or uterine cancer, and one
16 of whom shall be a medical specialist in gynecologic
17 cancers;

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

24 (E) eight members appointed by the Governor,
25 one of whom shall be a caregiver of a woman diagnosed
26 with a gynecologic cancer, one of whom shall be a

1 medical specialist in gynecologic cancers, one of whom
2 shall be an individual with expertise in community
3 based health care and issues affecting underserved and
4 vulnerable populations, 2 of whom shall be individuals
5 representing gynecologic cancer awareness and support
6 groups in the State, one of whom shall be a researcher
7 specializing in gynecologic cancers, and 2 of whom
8 shall be members of the public with demonstrated
9 expertise in issues relating to the work of the
10 Commission.

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

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

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

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

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

26 (3) determining best practices for closing disparities

1 in outcomes for gynecologic cancer patients and innovative
2 approaches to reaching underserved and vulnerable
3 populations;

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

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

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

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

15 Article 105.

16 Section 105-5. The Illinois Public Aid Code is amended by
17 changing Section 5A-12.7 as follows:

18 (305 ILCS 5/5A-12.7)

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

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

22 (a) To preserve and improve access to hospital services,

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

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

22 (c) Graduate medical education.

23 (1) The calculation of graduate medical education
24 payments shall be based on the hospital's Medicare cost
25 report ending in Calendar Year 2018, as reported in the
26 Healthcare Cost Report Information System file, release

1 date September 30, 2019. An Illinois hospital reporting
2 intern and resident cost on its Medicare cost report shall
3 be eligible for graduate medical education payments.

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

13 (3) An annualized Medicaid indirect medical education
14 (IME) payment is calculated for each hospital using its
15 IME payments (Worksheet E Part A, Line 29, Column 1)
16 multiplied by the percentage that its Medicaid days
17 (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18,
18 and 32) comprise of its Medicare days (Worksheet S3 Part
19 I, Column 6, Lines 2, 3, 4, 14, and 16-18).

20 (4) For each hospital, its annualized Medicaid Intern
21 Resident Cost and its annualized Medicaid IME payment are
22 summed, and, except as capped at 120% of the average cost
23 per intern and resident for all qualifying hospitals as
24 calculated under this paragraph, is multiplied by 22.6% to
25 determine the hospital's final graduate medical education
26 payment. Each hospital's average cost per intern and

1 resident shall be calculated by summing its total
2 annualized Medicaid Intern Resident Cost plus its
3 annualized Medicaid IME payment and dividing that amount
4 by the hospital's total Full Time Equivalent Residents and
5 Interns. If the hospital's average per intern and resident
6 cost is greater than 120% of the same calculation for all
7 qualifying hospitals, the hospital's per intern and
8 resident cost shall be capped at 120% of the average cost
9 for all qualifying hospitals.

10 (d) Fee-for-service supplemental payments. Each Illinois
11 hospital shall receive an annual payment equal to the amounts
12 below, to be paid in 12 equal installments on or before the
13 seventh State business day of each month, except that no
14 payment shall be due within 30 days after the later of the date
15 of notification of federal approval of the payment
16 methodologies required under this Section or any waiver
17 required under 42 CFR 433.68, at which time the sum of amounts
18 required under this Section prior to the date of notification
19 is due and payable.

20 (1) For critical access hospitals, \$385 per covered
21 inpatient day contained in paid fee-for-service claims and
22 \$530 per paid fee-for-service outpatient claim for dates
23 of service in Calendar Year 2019 in the Department's
24 Enterprise Data Warehouse as of May 11, 2020.

25 (2) For safety-net hospitals, \$960 per covered
26 inpatient day contained in paid fee-for-service claims and

1 \$625 per paid fee-for-service outpatient claim for dates
2 of service in Calendar Year 2019 in the Department's
3 Enterprise Data Warehouse as of May 11, 2020.

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

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

13 (5) For freestanding rehabilitation hospitals, \$355
14 per covered inpatient day contained in paid
15 fee-for-service claims for dates of service in Calendar
16 Year 2019 in the Department's Enterprise Data Warehouse as
17 of May 11, 2020.

18 (6) For all general acute care hospitals and high
19 Medicaid hospitals as defined in subsection (f), \$350 per
20 covered inpatient day for dates of service in Calendar
21 Year 2019 contained in paid fee-for-service claims and
22 \$620 per paid fee-for-service outpatient claim in the
23 Department's Enterprise Data Warehouse as of May 11, 2020.

24 (7) Alzheimer's treatment access payment. Each
25 Illinois academic medical center or teaching hospital, as
26 defined in Section 5-5e.2 of this Code, that is identified

1 as the primary hospital affiliate of one of the Regional
2 Alzheimer's Disease Assistance Centers, as designated by
3 the Alzheimer's Disease Assistance Act and identified in
4 the Department of Public Health's Alzheimer's Disease
5 State Plan dated December 2016, shall be paid an
6 Alzheimer's treatment access payment equal to the product
7 of the qualifying hospital's State Fiscal Year 2018 total
8 inpatient fee-for-service days multiplied by the
9 applicable Alzheimer's treatment rate of \$226.30 for
10 hospitals located in Cook County and \$116.21 for hospitals
11 located outside Cook County.

12 (e) The Department shall require managed care
13 organizations (MCOs) to make directed payments and
14 pass-through payments according to this Section. Each calendar
15 year, the Department shall require MCOs to pay the maximum
16 amount out of these funds as allowed as pass-through payments
17 under federal regulations. The Department shall require MCOs
18 to make such pass-through payments as specified in this
19 Section. The Department shall require the MCOs to pay the
20 remaining amounts as directed Payments as specified in this
21 Section. The Department shall issue payments to the
22 Comptroller by the seventh business day of each month for all
23 MCOs that are sufficient for MCOs to make the directed
24 payments and pass-through payments according to this Section.
25 The Department shall require the MCOs to make pass-through
26 payments and directed payments using electronic funds

1 transfers (EFT), if the hospital provides the information
2 necessary to process such EFTs, in accordance with directions
3 provided monthly by the Department, within 7 business days of
4 the date the funds are paid to the MCOs, as indicated by the
5 "Paid Date" on the website of the Office of the Comptroller if
6 the funds are paid by EFT and the MCOs have received directed
7 payment instructions. If funds are not paid through the
8 Comptroller by EFT, payment must be made within 7 business
9 days of the date actually received by the MCO. The MCO will be
10 considered to have paid the pass-through payments when the
11 payment remittance number is generated or the date the MCO
12 sends the check to the hospital, if EFT information is not
13 supplied. If an MCO is late in paying a pass-through payment or
14 directed payment as required under this Section (including any
15 extensions granted by the Department), it shall pay a penalty,
16 unless waived by the Department for reasonable cause, to the
17 Department equal to 5% of the amount of the pass-through
18 payment or directed payment not paid on or before the due date
19 plus 5% of the portion thereof remaining unpaid on the last day
20 of each 30-day period thereafter. Payments to MCOs that would
21 be paid consistent with actuarial certification and enrollment
22 in the absence of the increased capitation payments under this
23 Section shall not be reduced as a consequence of payments made
24 under this subsection. The Department shall publish and
25 maintain on its website for a period of no less than 8 calendar
26 quarters, the quarterly calculation of directed payments and

1 pass-through payments owed to each hospital from each MCO. All
2 calculations and reports shall be posted no later than the
3 first day of the quarter for which the payments are to be
4 issued.

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

9 (A) Critical access hospitals.

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

13 (C) Long term acute care hospitals.

14 (D) Freestanding psychiatric hospitals.

15 (E) Freestanding rehabilitation hospitals.

16 (F) High Medicaid hospitals. As used in this Section,
17 "high Medicaid hospital" means a general acute care
18 hospital that is not a safety-net hospital or critical
19 access hospital and that has a Medicaid Inpatient
20 Utilization Rate above 30% or a hospital that had over
21 35,000 inpatient Medicaid days during the applicable
22 period. For the period July 1, 2020 through December 31,
23 2020, the applicable period for the Medicaid Inpatient
24 Utilization Rate (MIUR) is the rate year 2020 MIUR and for
25 the number of inpatient days it is State fiscal year 2018.
26 Beginning in calendar year 2021, the Department shall use

1 the most recently determined MIUR, as defined in
2 subsection (h) of Section 5-5.02, and for the inpatient
3 day threshold, the State fiscal year ending 18 months
4 prior to the beginning of the calendar year. For purposes
5 of calculating MIUR under this Section, children's
6 hospitals and affiliated general acute care hospitals
7 shall be considered a single hospital.

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

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

17 (g) Fixed pool directed payments. Beginning July 1, 2020,
18 the Department shall issue payments to MCOs which shall be
19 used to issue directed payments to qualified Illinois
20 safety-net hospitals and critical access hospitals on a
21 monthly basis in accordance with this subsection. Prior to the
22 beginning of each Payout Quarter beginning July 1, 2020, the
23 Department shall use encounter claims data from the
24 Determination Quarter, accepted by the Department's Medicaid
25 Management Information System for inpatient and outpatient
26 services rendered by safety-net hospitals and critical access

1 hospitals to determine a quarterly uniform per unit add-on for
2 each hospital class.

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

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

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

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

26 (A) Each hospital in the class shall have a

1 quarterly outpatient directed payment calculated that
2 is equal to the product of the number of outpatient
3 encounter claims attributable to the hospital used in
4 the calculation of the quarterly uniform class per
5 claim add-on, multiplied by the calculated applicable
6 quarterly uniform class per claim add-on of the
7 hospital class.

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

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

15 (4) Definitions. As used in this subsection:

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

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

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

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

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

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

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

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

19 (1) For general acute care hospitals an amount equal
20 to \$1,750 multiplied by the hospital's category of service
21 20 case mix index for the determination quarter multiplied
22 by the hospital's total number of inpatient admissions for
23 category of service 20 for the determination quarter.

24 (2) For general acute care hospitals an amount equal
25 to \$160 multiplied by the hospital's category of service
26 21 case mix index for the determination quarter multiplied

1 by the hospital's total number of inpatient admissions for
2 category of service 21 for the determination quarter.

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

8 (4) For general acute care hospitals an amount equal
9 to \$375 multiplied by the hospital's category of service
10 24 case mix index for the determination quarter multiplied
11 by the hospital's total number of category of service 24
12 paid EAPG (EAPGs) for the determination quarter.

13 (5) For general acute care hospitals an amount equal
14 to \$240 multiplied by the hospital's category of service
15 27 and 28 case mix index for the determination quarter
16 multiplied by the hospital's total number of category of
17 service 27 and 28 paid EAPGs for the determination
18 quarter.

19 (6) For general acute care hospitals an amount equal
20 to \$290 multiplied by the hospital's category of service
21 29 case mix index for the determination quarter multiplied
22 by the hospital's total number of category of service 29
23 paid EAPGs for the determination quarter.

24 (7) For high Medicaid hospitals an amount equal to
25 \$1,800 multiplied by the hospital's category of service 20
26 case mix index for the determination quarter multiplied by

1 the hospital's total number of inpatient admissions for
2 category of service 20 for the determination quarter.

3 (8) For high Medicaid hospitals an amount equal to
4 \$160 multiplied by the hospital's category of service 21
5 case mix index for the determination quarter multiplied by
6 the hospital's total number of inpatient admissions for
7 category of service 21 for the determination quarter.

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

13 (10) For high Medicaid hospitals an amount equal to
14 \$400 multiplied by the hospital's category of service 24
15 case mix index for the determination quarter multiplied by
16 the hospital's total number of category of service 24 paid
17 EAPG outpatient claims for the determination quarter.

18 (11) For high Medicaid hospitals an amount equal to
19 \$240 multiplied by the hospital's category of service 27
20 and 28 case mix index for the determination quarter
21 multiplied by the hospital's total number of category of
22 service 27 and 28 paid EAPGs for the determination
23 quarter.

24 (12) For high Medicaid hospitals an amount equal to
25 \$290 multiplied by the hospital's category of service 29
26 case mix index for the determination quarter multiplied by

1 the hospital's total number of category of service 29 paid
2 EAPGs for the determination quarter.

3 (13) For long term acute care hospitals the amount of
4 \$495 multiplied by the hospital's total number of
5 inpatient days for the determination quarter.

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

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

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

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

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

26 (19) Each MCO shall pay each hospital the Monthly

1 Directed Payment amount as identified by the Department on
2 its quarterly determination report.

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

13 Definitions. As used in this subsection:

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

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

19 (C) "Case mix index" means a hospital specific
20 calculation. For inpatient claims the case mix index
21 is calculated each quarter by summing the relative
22 weight of all inpatient Diagnosis-Related Group (DRG)
23 claims for a category of service in the applicable
24 Determination Quarter and dividing the sum by the
25 number of sum total of all inpatient DRG admissions
26 for the category of service for the associated claims.

1 The case mix index for outpatient claims is calculated
2 each quarter by summing the relative weight of all
3 paid EAPGs in the applicable Determination Quarter and
4 dividing the sum by the sum total of paid EAPGs for the
5 associated claims.

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

13 (j) Pass-through payments.

14 (1) For the period July 1, 2020 through December 31,
15 2020, the Department shall assign quarterly pass-through
16 payments to each class of hospitals equal to one-fourth of
17 the following annual allocations:

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

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

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

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

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

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

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

1 (2) The pass-through payments shall at a minimum
2 ensure hospitals receive a total amount of monthly
3 payments under this Section as received in calendar year
4 2019 in accordance with this Article and paragraph (1) of
5 subsection (d-5) of Section 14-12, exclusive of amounts
6 received through payments referenced in subsection (b).

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

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

19 (l) Notwithstanding any other provisions of this Section,
20 the Department may adopt rules to change the methodology for
21 directed and pass-through payments as set forth in this
22 Section, but only to the extent necessary to obtain federal
23 approval of a necessary State Plan amendment or Directed
24 Payment Preprint or to otherwise conform to federal law or
25 federal regulation.

26 (m) As used in this subsection, "managed care

1 organization" or "MCO" means an entity which contracts with
2 the Department to provide services where payment for medical
3 services is made on a capitated basis, excluding contracted
4 entities for dual eligible or Department of Children and
5 Family Services youth populations.

6 (n) In order to address the escalating infant mortality
7 rates among minority communities in Illinois, the State shall,
8 subject to appropriation, create a pool of funding of at least
9 \$50,000,000 annually to be disbursed among safety-net
10 hospitals that maintain perinatal designation from the
11 Department of Public Health. The funding shall be used to
12 preserve or enhance OB/GYN services or other specialty
13 services at the receiving hospital, with the distribution of
14 funding to be established by rule and with consideration to
15 perinatal hospitals with safe birthing levels and quality
16 metrics for healthy mothers and babies.

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

18 Article 110.

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

21 Section 110-5. Racial impact note.

22 (a) Every bill which has or could have a disparate impact
23 on racial and ethnic minorities, upon the request of any

1 member, shall have prepared for it, before second reading in
2 the house of introduction, a brief explanatory statement or
3 note that shall include a reliable estimate of the anticipated
4 impact on those racial and ethnic minorities likely to be
5 impacted by the bill. Each racial impact note must include,
6 for racial and ethnic minorities for which data are available:
7 (i) an estimate of how the proposed legislation would impact
8 racial and ethnic minorities; (ii) a statement of the
9 methodologies and assumptions used in preparing the estimate;
10 (iii) an estimate of the racial and ethnic composition of the
11 population who may be impacted by the proposed legislation,
12 including those persons who may be negatively impacted and
13 those persons who may benefit from the proposed legislation;
14 and (iv) any other matter that a responding agency considers
15 appropriate in relation to the racial and ethnic minorities
16 likely to be affected by the bill.

17 Section 110-10. Preparation.

18 (a) The sponsor of each bill for which a request under
19 Section 110-5 has been made shall present a copy of the bill
20 with the request for a racial impact note to the appropriate
21 responding agency or agencies under subsection (b). The
22 responding agency or agencies shall prepare and submit the
23 note to the sponsor of the bill within 5 calendar days, except
24 that whenever, because of the complexity of the measure,
25 additional time is required for the preparation of the racial

1 impact note, the responding agency or agencies may inform the
2 sponsor of the bill, and the sponsor may approve an extension
3 of the time within which the note is to be submitted, not to
4 extend, however, beyond June 15, following the date of the
5 request. If, in the opinion of the responding agency or
6 agencies, there is insufficient information to prepare a
7 reliable estimate of the anticipated impact, a statement to
8 that effect can be filed and shall meet the requirements of
9 this Act.

10 (b) If a bill concerns arrests, convictions, or law
11 enforcement, a statement shall be prepared by the Illinois
12 Criminal Justice Information Authority specifying the impact
13 on racial and ethnic minorities. If a bill concerns
14 corrections, sentencing, or the placement of individuals
15 within the Department of Corrections, a statement shall be
16 prepared by the Department of Corrections specifying the
17 impact on racial and ethnic minorities. If a bill concerns
18 local government, a statement shall be prepared by the
19 Department of Commerce and Economic Opportunity specifying the
20 impact on racial and ethnic minorities. If a bill concerns
21 education, one of the following agencies shall prepare a
22 statement specifying the impact on racial and ethnic
23 minorities: (i) the Illinois Community College Board, if the
24 bill affects community colleges; (ii) the Illinois State Board
25 of Education, if the bill affects primary and secondary
26 education; or (iii) the Illinois Board of Higher Education, if

1 the bill affects State universities. Any other State agency
2 impacted or responsible for implementing all or part of this
3 bill shall prepare a statement of the racial and ethnic impact
4 of the bill as it relates to that agency.

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

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

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

1 responding agency or agencies, or any other impacted State
2 agency, who desires to be heard in support of or in opposition
3 to the measure.

4 Article 115.

5 Section 115-5. The Illinois Public Aid Code is amended by
6 adding Section 14-14 as follows:

7 (305 ILCS 5/14-14 new)

8 Sec. 14-14. Increasing access to primary care in
9 hospitals. The Department of Healthcare and Family Services
10 shall develop a program to facilitate coordination between
11 Federally Qualified Health Centers (FQHCs) and safety net
12 hospitals, with the goal of increasing care coordination,
13 managing chronic diseases, and addressing the social
14 determinants of health on or before December 31, 2021.
15 Coordination between FQHCs and safety hospitals may include,
16 but is not limited to, embedding FQHC staff in hospitals,
17 utilizing health information technology for care coordination,
18 and enabling FQHCs to connect hospital patients to
19 community-based resources when needed to provide whole-person
20 care. In addition, the Department shall develop a payment
21 methodology to allow FQHCs to provide care coordination
22 services, including, but not limited to, chronic disease
23 management and behavioral health services. The Department of

1 Healthcare and Family Services shall develop a payment
2 methodology to allow for FQHC care coordination services by no
3 later than December 31, 2021.

4 Article 120.

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

7 (20 ILCS 5/5-565) (was 20 ILCS 5/6.06)

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

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

21 (1) Needs assessment.

22 (2) Statewide health objectives.

23 (3) Policy development.

1 (4) Assurance of access to necessary services.

2 There shall be a State Board of Health composed of 20
3 persons, all of whom shall be appointed by the Governor, with
4 the advice and consent of the Senate for those appointed by the
5 Governor on and after June 30, 1998, and one of whom shall be a
6 senior citizen age 60 or over. Five members shall be
7 physicians licensed to practice medicine in all its branches,
8 one representing a medical school faculty, one who is board
9 certified in preventive medicine, and one who is engaged in
10 private practice. One member shall be a chiropractic
11 physician. One member shall be a dentist; one an environmental
12 health practitioner; one a local public health administrator;
13 one a local board of health member; one a registered nurse; one
14 a physical therapist; one an optometrist; one a veterinarian;
15 one a public health academician; one a health care industry
16 representative; one a representative of the business
17 community; one a representative of the non-profit public
18 interest community; and 2 shall be citizens at large.

19 The terms of Board of Health members shall be 3 years,
20 except that members shall continue to serve on the Board of
21 Health until a replacement is appointed. Upon the effective
22 date of Public Act 93-975 (January 1, 2005) ~~this amendatory~~
23 ~~Act of the 93rd General Assembly~~, in the appointment of the
24 Board of Health members appointed to vacancies or positions
25 with terms expiring on or before December 31, 2004, the
26 Governor shall appoint up to 6 members to serve for terms of 3

1 years; up to 6 members to serve for terms of 2 years; and up to
2 5 members to serve for a term of one year, so that the term of
3 no more than 6 members expire in the same year. All members
4 shall be legal residents of the State of Illinois. The duties
5 of the Board shall include, but not be limited to, the
6 following:

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

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

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

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

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

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

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

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

4 (5) To present public health issues to the Director
5 and to make recommendations for the resolution of those
6 issues.

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

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

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

16 (9) To review the final draft of all proposed
17 administrative rules, other than emergency or peremptory
18 ~~preemptory~~ rules and those rules that another advisory
19 body must approve or review within a statutorily defined
20 time period, of the Department after September 19, 1991
21 (the effective date of Public Act 87-633). The Board shall
22 review the proposed rules within 90 days of submission by
23 the Department. The Department shall take into
24 consideration any comments and recommendations of the
25 Board regarding the proposed rules prior to submission to
26 the Secretary of State for initial publication. If the

1 Department disagrees with the recommendations of the
2 Board, it shall submit a written response outlining the
3 reasons for not accepting the recommendations.

4 In the case of proposed administrative rules or
5 amendments to administrative rules regarding immunization
6 of children against preventable communicable diseases
7 designated by the Director under the Communicable Disease
8 Prevention Act, after the Immunization Advisory Committee
9 has made its recommendations, the Board shall conduct 3
10 public hearings, geographically distributed throughout the
11 State. At the conclusion of the hearings, the State Board
12 of Health shall issue a report, including its
13 recommendations, to the Director. The Director shall take
14 into consideration any comments or recommendations made by
15 the Board based on these hearings.

16 (10) To deliver to the Governor for presentation to
17 the General Assembly a State Health Assessment (SHA) and a
18 State Health Improvement Plan (SHIP). The first 5 ~~3~~ such
19 plans shall be delivered to the Governor on January 1,
20 2006, January 1, 2009, ~~and~~ January 1, 2016, January 1,
21 2021, and June 30, 2022, and then every 5 years
22 thereafter.

23 The State Health Assessment and State Health
24 Improvement Plan ~~Plan~~ shall assess and recommend
25 priorities and strategies to improve the public health
26 system, ~~and~~ the health status of Illinois residents,

1 reduce health disparities and inequities, and promote
2 health equity. The State Health Assessment and State
3 Health Improvement Plan development and implementation
4 shall conform to national Public Health Accreditation
5 Board Standards. The State Health Assessment and State
6 Health Improvement Plan development and implementation
7 process shall be carried out with the administrative and
8 operational support of the Department of Public Health
9 ~~taking into consideration national health objectives and~~
10 ~~system standards as frameworks for assessment.~~

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

15 (i) quantitative data, if it is available, on the
16 demographics and health status of the population,
17 including data over time on health by gender identity,
18 sexual orientation, race, ethnicity, age,
19 socio-economic factors, geographic region, disability
20 status, and other indicators of disparity;

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

26 (iii) priorities and strategies developed at the

1 community level through the Illinois Project for Local
2 Assessment of Needs (IPLAN) and other local and
3 regional community health needs assessments;

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

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

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

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

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

21 The State Health Improvement Plan ~~Plan~~ shall identify
22 priority State health issues and social issues affecting
23 health, and shall examine and make recommendations on the
24 contributions and strategies of the public and private
25 sectors for improving health status and the public health
26 system in the State. In addition to recommendations on

1 health status improvement priorities and strategies for
2 the population of the State as a whole, the State Health
3 Improvement Plan ~~Plan~~ shall make recommendations, provided
4 that data exists to support such recommendations,
5 regarding priorities and strategies for reducing and
6 eliminating health disparities and health inequities in
7 Illinois; including racial, ethnic, gender identification,
8 sexual orientation, age, disability, socio-economic, and
9 geographic disparities. The State Health Improvement Plan
10 shall make recommendations regarding social determinants
11 of health, such as housing, transportation, educational
12 attainment, employment, and income inequality.

13 The development and implementation of the State Health
14 Assessment and State Health Improvement Plan shall be a
15 collaborative public-private cross-agency effort overseen
16 by the SHA and SHIP Partnership. The Director of Public
17 Health shall consult with the Governor to ensure
18 participation by the head of State agencies with public
19 health responsibilities (or their designees) in the SHA
20 and SHIP Partnership, including, but not limited to, the
21 Department of Public Health, the Department of Human
22 Services, the Department of Healthcare and Family
23 Services, the Department of Children and Family Services,
24 the Environmental Protection Agency, the Illinois State
25 Board of Education, the Department on Aging, the Illinois
26 Housing Development Authority, the Illinois Criminal

1 Justice Information Authority, the Department of
2 Agriculture, the Department of Transportation, the
3 Department of Corrections, the Department of Commerce and
4 Economic Opportunity, and the Chair of the State Board of
5 Health to also serve on the Partnership. A member of the
6 Governor's staff shall participate in the Partnership and
7 serve as a liaison to the Governor's office.

8 The Director of ~~the Illinois Department of~~ Public
9 Health shall appoint a minimum of 15 other members of the
10 SHA and SHIP Partnership representing a Planning Team that
11 ~~includes~~ a range of public, private, and voluntary sector
12 stakeholders and participants in the public health system.
13 For the first SHA and SHIP Partnership after the effective
14 date of this amendatory Act of the 102nd General Assembly,
15 one-half of the members shall be appointed for a 3-year
16 term, and one-half of the members shall be appointed for a
17 5-year term. Subsequently, members shall be appointed to
18 5-year terms. Should any member not be able to fulfill his
19 or her term, the Director may appoint a replacement to
20 complete that term. The Director, in consultation with the
21 SHA and SHIP Partnership, may engage additional
22 individuals and organizations to serve on subcommittees
23 and ad hoc efforts to conduct the State Health Assessment
24 and develop and implement the State Health Improvement
25 Plan. Members of the SHA and SHIP Partnership shall
26 receive no compensation for serving as members, but may be

1 reimbursed for their necessary expenses if departmental
2 resources allow.

3 The SHA and SHIP Partnership ~~This Team~~ shall include:
4 ~~the directors of State agencies with public health~~
5 ~~responsibilities (or their designees), including but not~~
6 ~~limited to the Illinois Departments of Public Health and~~
7 ~~Department of Human Services,~~ representatives of local
8 health departments, ~~representatives of local community~~
9 ~~health partnerships,~~ and individuals with expertise who
10 represent an array of organizations and constituencies
11 engaged in public health improvement and prevention, such
12 as non-profit public interest groups, groups serving
13 populations that experience health disparities and health
14 inequities, groups addressing social determinants of
15 health, health issue groups, faith community groups,
16 health care providers, businesses and employers, academic
17 institutions, and community-based organizations.

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

24 The SHA and SHIP Partnership shall develop and
25 implement a community engagement process that facilitates
26 input into the development of the State Health Assessment

1 and State Health Improvement Plan. This engagement process
2 shall ensure that individuals with lived experience in the
3 issues addressed in the State Health Assessment and State
4 Health Improvement Plan are meaningfully engaged in the
5 development and implementation of the State Health
6 Assessment and State Health Improvement Plan.

7 The State Board of Health shall hold at least 3 public
8 hearings addressing a draft of the State Health
9 Improvement Plan ~~drafts of the Plan~~ in representative
10 geographic areas of the State. ~~Members of the Planning~~
11 ~~Team shall receive no compensation for their services, but~~
12 ~~may be reimbursed for their necessary expenses.~~

13 ~~Upon the delivery of each State Health Improvement~~
14 ~~Plan, the Governor shall appoint a SHIP Implementation~~
15 ~~Coordination Council that includes a range of public,~~
16 ~~private, and voluntary sector stakeholders and~~
17 ~~participants in the public health system. The Council~~
18 ~~shall include the directors of State agencies and entities~~
19 ~~with public health system responsibilities (or their~~
20 ~~designees), including but not limited to the Department of~~
21 ~~Public Health, Department of Human Services, Department of~~
22 ~~Healthcare and Family Services, Environmental Protection~~
23 ~~Agency, Illinois State Board of Education, Department on~~
24 ~~Aging, Illinois Violence Prevention Authority, Department~~
25 ~~of Agriculture, Department of Insurance, Department of~~
26 ~~Financial and Professional Regulation, Department of~~

1 ~~Transportation, and Department of Commerce and Economic~~
2 ~~Opportunity and the Chair of the State Board of Health.~~
3 ~~The Council shall include representatives of local health~~
4 ~~departments and individuals with expertise who represent~~
5 ~~an array of organizations and constituencies engaged in~~
6 ~~public health improvement and prevention, including~~
7 ~~non profit public interest groups, health issue groups,~~
8 ~~faith community groups, health care providers, businesses~~
9 ~~and employers, academic institutions, and community based~~
10 ~~organizations. The Governor shall endeavor to make the~~
11 ~~membership of the Council representative of the racial,~~
12 ~~ethnic, gender, socio-economic, and geographic diversity~~
13 ~~of the State. The Governor shall designate one State~~
14 ~~agency representative and one other non-governmental~~
15 ~~member as co-chairs of the Council. The Governor shall~~
16 ~~designate a member of the Governor's office to serve as~~
17 ~~liaison to the Council and one or more State agencies to~~
18 ~~provide or arrange for support to the Council. The members~~
19 ~~of the SHIP Implementation Coordination Council for each~~
20 ~~State Health Improvement Plan shall serve until the~~
21 ~~delivery of the subsequent State Health Improvement Plan,~~
22 ~~whereupon a new Council shall be appointed. Members of the~~
23 ~~SHIP Planning Team may serve on the SHIP Implementation~~
24 ~~Coordination Council if so appointed by the Governor.~~

25 Upon the delivery of each State Health Assessment and
26 State Health Improvement Plan, the SHA and SHIP

1 Partnership ~~The SHIP Implementation Coordination Council~~
2 shall coordinate the efforts and engagement of the public,
3 private, and voluntary sector stakeholders and
4 participants in the public health system to implement each
5 SHIP. The Partnership Council shall serve as a forum for
6 collaborative action; coordinate existing and new
7 initiatives; develop detailed implementation steps, with
8 mechanisms for action; implement specific projects;
9 identify public and private funding sources at the local,
10 State and federal level; promote public awareness of the
11 SHIP; and advocate for the implementation of the SHIP. The
12 SHA and SHIP Partnership shall implement strategies to
13 ensure that individuals and communities affected by health
14 disparities and health inequities are engaged in the
15 process throughout the 5-year cycle. The SHA and SHIP
16 Partnership shall regularly evaluate and update the State
17 Health Assessment and track implementation of the State
18 Health Improvement Plan with revisions as necessary. The
19 SHA and SHIP Partnership shall not have the authority to
20 direct any public or private entity to take specific
21 action to implement the SHIP. ~~; and develop an annual~~
22 ~~report to the Governor, General Assembly, and public~~
23 ~~regarding the status of implementation of the SHIP. The~~
24 ~~Council shall not, however, have the authority to direct~~
25 ~~any public or private entity to take specific action to~~
26 ~~implement the SHIP.~~

1 The State Board of Health shall submit a report by
2 January 31 of each year on the status of State Health
3 Improvement Plan implementation and community engagement
4 activities to the Governor, General Assembly, and public.
5 In the fifth year, the report may be consolidated into the
6 new State Health Assessment and State Health Improvement
7 Plan.

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

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

15 (13) (Blank).

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

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

1 (b) (Blank).

2 (c) An Advisory Board on Necropsy Service to Coroners,
3 which shall counsel and advise with the Director on the
4 administration of the Autopsy Act. The Advisory Board shall
5 consist of 11 members, including a senior citizen age 60 or
6 over, appointed by the Governor, one of whom shall be
7 designated as chairman by a majority of the members of the
8 Board. In the appointment of the first Board the Governor
9 shall appoint 3 members to serve for terms of 1 year, 3 for
10 terms of 2 years, and 3 for terms of 3 years. The members first
11 appointed under Public Act 83-1538 shall serve for a term of 3
12 years. All members appointed thereafter shall be appointed for
13 terms of 3 years, except that when an appointment is made to
14 fill a vacancy, the appointment shall be for the remaining
15 term of the position vacant. The members of the Board shall be
16 citizens of the State of Illinois. In the appointment of
17 members of the Advisory Board the Governor shall appoint 3
18 members who shall be persons licensed to practice medicine and
19 surgery in the State of Illinois, at least 2 of whom shall have
20 received post-graduate training in the field of pathology; 3
21 members who are duly elected coroners in this State; and 5
22 members who shall have interest and abilities in the field of
23 forensic medicine but who shall be neither persons licensed to
24 practice any branch of medicine in this State nor coroners. In
25 the appointment of medical and coroner members of the Board,
26 the Governor shall invite nominations from recognized medical

1 and coroners organizations in this State respectively. Board
2 members, while serving on business of the Board, shall receive
3 actual necessary travel and subsistence expenses while so
4 serving away from their places of residence.

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

7 Article 125.

8 Section 125-1. Short title. This Article may be cited as
9 the Health and Human Services Task Force and Study Act.
10 References in this Article to "this Act" mean this Article.

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

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

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

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

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

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

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

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

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

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

21 (10) Infants, children, and youth and their families
22 who have experienced or are at risk of experiencing
23 trauma, including those who are low-income, homeless,
24 involved with the child welfare system, involved in the
25 juvenile or adult justice system, unemployed, or not
26 enrolled in or at risk of dropping out of an educational

1 institution and live in a community that has faced acute
2 or long-term exposure to substantial discrimination,
3 historical oppression, intergenerational poverty, a high
4 rate of violence or drug overdose deaths, should have an
5 opportunity for improved outcomes; this means increasing
6 access to greater opportunities to meet educational,
7 employment, health, developmental, community reentry,
8 permanency from foster care, or other key goals.

9 Section 125-10. Health and Human Services Task Force. The
10 Health and Human Services Task Force is created within the
11 Department of Human Services to undertake a systematic review
12 of health and human service departments and programs with the
13 goal of improving health and human service outcomes for
14 Illinois residents.

15 Section 125-15. Study.

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

24 (i) impact on infant and maternal mortality;

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

3 (iii) impact on Medicaid Managed Care Organizations.

4 (2) The Task Force shall review and make recommendations
5 on ways the Medicaid program can partner and cooperate with
6 other agencies, including but not limited to the Department of
7 Agriculture, the Department of Insurance, the Department of
8 Human Services, the Department of Labor, the Environmental
9 Protection Agency, and the Department of Public Health, to
10 better address social determinants of public health,
11 including, but not limited to, food deserts, affordable
12 housing, environmental pollutions, employment, education, and
13 public support services. This shall include a review and
14 recommendations on ways Medicaid and the agencies can share
15 costs related to better health outcomes.

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

23 (4) The Task Force shall review and examine public
24 policies affecting trauma and social determinants of health,
25 including trauma-informed care, and make recommendations on
26 ways to improve and integrate trauma-informed approaches into

1 programs and agencies in the State, including, but not limited
2 to, Medicaid and other health care programs administered by
3 the State, and increase awareness of trauma and its effects on
4 communities across Illinois.

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

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

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

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

25 (B) One member of the House of Representatives,

1 appointed by the Speaker of the House, who shall serve as
2 Co-Chair;

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

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

8 (i) Department of Human Services.

9 (ii) Department of Children and Family Services.

10 (iii) Department of Healthcare and Family
11 Services.

12 (iv) State Board of Education.

13 (v) Department on Aging.

14 (vi) Department of Public Health.

15 (vii) Department of Veterans' Affairs.

16 (viii) Department of Insurance.

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

21 (i) Early childhood education and development.

22 (ii) Child care.

23 (iii) Child welfare.

24 (iv) Youth services.

25 (v) Developmental disabilities.

26 (vi) Mental health.

- 1 (vii) Employment and training.
- 2 (viii) Sexual and domestic violence.
- 3 (ix) Alcohol and substance abuse.
- 4 (x) Local community collaborations among human
5 services programs.
- 6 (xi) Immigrant services.
- 7 (xii) Affordable housing.
- 8 (xiii) Food and nutrition.
- 9 (xiv) Homelessness.
- 10 (xv) Older adults.
- 11 (xvi) Physical disabilities.
- 12 (xvii) Maternal and child health.
- 13 (xviii) Medicaid managed care organizations.
- 14 (xix) Healthcare delivery.
- 15 (xx) Health insurance.

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

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

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

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

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

7 Section 125-30. Transparency. In addition to whatever
8 policies or procedures it may adopt, all operations of the
9 Task Force shall be subject to the provisions of the Freedom of
10 Information Act and the Open Meetings Act. This Section shall
11 not be construed so as to preclude other State laws from
12 applying to the Task Force and its activities.

13 Section 125-40. Repeal. This Article is repealed June 30,
14 2023.

15 Article 130.

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

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

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

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

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

25 (4) Black and Brown people are more likely to
26 experience poor health outcomes as a consequence of their

1 social determinants of health, health inequities stemming
2 from economic instability, education, physical
3 environment, food, and access to health care systems.

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

8 (6) Racism is a social system with multiple dimensions
9 in which individual racism is internalized or
10 interpersonal and systemic racism is institutional or
11 structural and is a system of structuring opportunity and
12 assigning value based on the social interpretation of how
13 one looks; this unfairly disadvantages specific
14 individuals and communities, while unfairly giving
15 advantages to other individuals and communities; it saps
16 the strength of the whole society through the waste of
17 human resources.

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

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

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

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

4 Section 130-10. Anti-Racism Commission.

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

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

11 (1) one member of the House of Representatives,
12 appointed by the Speaker of the House of Representatives,
13 who shall serve as co-chair;

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

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

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

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

23 (6) the Chair of the House Black Caucus;

24 (7) the Chair of the Senate Black Caucus;

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

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

4 (10) the Chair of the House Latino Caucus;

5 (11) the Chair of the Senate Latino Caucus;

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

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

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

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

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

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

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

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

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

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

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

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

13 (7) Reviewing all portions of codified State laws
14 through the lens of racial equity.

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

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

23 (10) Promoting and supporting all policies that
24 prioritize the health of all people, especially people of
25 color, by mitigating exposure to adverse childhood
26 experiences and trauma in childhood and ensuring

1 implementation of health and equity in all policies.

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

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

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

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

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

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

18 (e) The Commission shall submit its final report to the
19 Governor and the General Assembly no later than December 31,
20 2021. The Commission is dissolved upon the filing of its
21 report.

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

24 Article 131.

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

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

5 "Department" means the Department of Public Health.

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

8 Section 131-10. Sickle Cell Prevention, Care, and
9 Treatment Program. The Department shall establish a grant
10 program for the purpose of providing for the prevention, care,
11 and treatment of sickle cell disease and for educational
12 programs concerning the disease.

13 Section 131-15. Grants; eligibility standards.

14 (a) The Department shall do the following:

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

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

20 However:

21 (i) the highest priority for grants shall be
22 accorded to established sickle cell disease

1 community-based organizations throughout Illinois; and
2 (ii) priority shall also be given to ensuring the
3 establishment of sickle cell disease centers in
4 underserved areas that have a higher population of
5 sickle cell disease patients.

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

8 (3) Determine policies for the expiration and renewal
9 of grants provided under subparagraph (B) of paragraph
10 (1).

11 (4) Require that all grant funds be used for the
12 purpose of prevention, care, and treatment of sickle cell
13 disease or for educational programs concerning the
14 disease. Grant funds shall be used for one or more of the
15 following purposes:

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

20 (i) Self-administered care.

21 (ii) Preventive care.

22 (iii) Home care.

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

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

3 (C) Establishing additional sickle cell disease
4 infusion centers.

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

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

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

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

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

20 (aa) Social service counseling.

21 (bb) Psychological counseling.

22 (cc) Psychiatric counseling.

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

1 (A) Medical residents.

2 (B) Immigrants.

3 (C) Schools and universities.

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

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

9 Section 131-20. Sickle Cell Chronic Disease Fund.

10 (a) The Sickle Cell Chronic Disease Fund is created as a
11 special fund in the State treasury for the purpose of carrying
12 out the provisions of this Act and for no other purpose. The
13 Fund shall be administered by the Department. Expenditures
14 from the Fund shall be subject to appropriation.

15 (b) The Fund shall consist of:

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

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

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

20 Section 131-25. Study.

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

23 (1) the Center for Minority Health Services;

24 (2) health care providers that treat individuals with

1 sickle cell disease;

2 (3) individuals diagnosed with sickle cell disease;

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

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

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

10 (b) The study must include the following:

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

14 (2) The prevalence, by geographic location, of
15 individuals diagnosed as sickle cell trait carriers in
16 Illinois.

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

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

22 (A) Treatment centers.

23 (B) Clinics.

24 (C) Community-based social service organizations.

25 (D) Medical specialists.

26 (5) The unmet medical, psychological, and social needs

1 encountered by individuals in Illinois with sickle cell
2 disease.

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

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

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

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

11 Section 131-90. The State Finance Act is amended by adding
12 Section 5.937 as follows:

13 (30 ILCS 105/5.937 new)

14 Sec. 5.937. The Sickle Cell Chronic Disease Fund.

15 Title VII. Hospital Closure

16 Article 135.

17 Section 135-5. The Illinois Health Facilities Planning Act
18 is amended by changing Sections 4, 5.4, and 8.7 as follows:

19 (20 ILCS 3960/4) (from Ch. 111 1/2, par. 1154)

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

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

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

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

22 Each member shall have a reasonable knowledge of the
23 practice, procedures and principles of the health care
24 delivery system in Illinois, including at least 5 members who
25 shall be knowledgeable about health care delivery systems,
26 health systems planning, finance, or the management of health

1 care facilities currently regulated under the Act. One member
2 shall be a representative of a non-profit health care consumer
3 advocacy organization. One member shall be a representative
4 from the community with experience on the effects of
5 discontinuing health care services or the closure of health
6 care facilities on the surrounding community; provided,
7 however, that all other members of the Board shall be
8 appointed before this member shall be appointed. A spouse,
9 parent, sibling, or child of a Board member cannot be an
10 employee, agent, or under contract with services or facilities
11 subject to the Act. Prior to appointment and in the course of
12 service on the Board, members of the Board shall disclose the
13 employment or other financial interest of any other relative
14 of the member, if known, in service or facilities subject to
15 the Act. Members of the Board shall declare any conflict of
16 interest that may exist with respect to the status of those
17 relatives and recuse themselves from voting on any issue for
18 which a conflict of interest is declared. No person shall be
19 appointed or continue to serve as a member of the State Board
20 who is, or whose spouse, parent, sibling, or child is, a member
21 of the Board of Directors of, has a financial interest in, or
22 has a business relationship with a health care facility.

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

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

5 (c) The State Board shall be appointed by the Governor,
6 with the advice and consent of the Senate. Not more than 6 ~~5~~ of
7 the appointments shall be of the same political party at the
8 time of the appointment.

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

13 (d) Of those ~~9~~ members initially appointed by the Governor
14 following the effective date of this amendatory Act of the
15 96th General Assembly, 3 shall serve for terms expiring July
16 1, 2011, 3 shall serve for terms expiring July 1, 2012, and 3
17 shall serve for terms expiring July 1, 2013. Thereafter, each
18 appointed member shall hold office for a term of 3 years,
19 provided that any member appointed to fill a vacancy occurring
20 prior to the expiration of the term for which his or her
21 predecessor was appointed shall be appointed for the remainder
22 of such term and the term of office of each successor shall
23 commence on July 1 of the year in which his predecessor's term
24 expires. Each member shall hold office until his or her
25 successor is appointed and qualified. The Governor may
26 reappoint a member for additional terms, but no member shall

1 serve more than 3 terms, subject to review and re-approval
2 every 3 years.

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

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

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

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

1 (i) ~~Six Five~~ members of the State Board shall constitute a
2 quorum. The affirmative vote of 6 ~~5~~ of the members of the State
3 Board shall be necessary for any action requiring a vote to be
4 taken by the State Board. A vacancy in the membership of the
5 State Board shall not impair the right of a quorum to exercise
6 all the rights and perform all the duties of the State Board as
7 provided by this Act.

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

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

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

18 (20 ILCS 3960/5.4)

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

20 Sec. 5.4. Safety Net Impact Statement.

21 (a) General review criteria shall include a requirement
22 that all health care facilities, with the exception of skilled
23 and intermediate long-term care facilities licensed under the
24 Nursing Home Care Act, provide a Safety Net Impact Statement,
25 which shall be filed with an application for a substantive

1 project or when the application proposes to discontinue a
2 category of service.

3 (b) For the purposes of this Section, "safety net
4 services" are services provided by health care providers or
5 organizations that deliver health care services to persons
6 with barriers to mainstream health care due to lack of
7 insurance, inability to pay, special needs, ethnic or cultural
8 characteristics, or geographic isolation. Safety net service
9 providers include, but are not limited to, hospitals and
10 private practice physicians that provide charity care,
11 school-based health centers, migrant health clinics, rural
12 health clinics, federally qualified health centers, community
13 health centers, public health departments, and community
14 mental health centers.

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

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

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

25 (3) How the discontinuation of a facility or service
26 might impact the remaining safety net providers in a given

1 community, if reasonably known by the applicant.

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

4 (1) For the 3 fiscal years prior to the application, a
5 certification describing the amount of charity care
6 provided by the applicant. The amount calculated by
7 hospital applicants shall be in accordance with the
8 reporting requirements for charity care reporting in the
9 Illinois Community Benefits Act. Non-hospital applicants
10 shall report charity care, at cost, in accordance with an
11 appropriate methodology specified by the Board.

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

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

24 (e) The Board staff shall publish a notice, that an
25 application accompanied by a Safety Net Impact Statement has
26 been filed, in a newspaper having general circulation within

1 the area affected by the application. If no newspaper has a
2 general circulation within the county, the Board shall post
3 the notice in 5 conspicuous places within the proposed area.

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

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

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

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

22 (20 ILCS 3960/8.7)

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

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

1 public hearing.

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

21 An application to close a health care facility shall only
22 be deemed complete if it includes evidence that the health
23 care facility provided written notice at least 30 days prior
24 to filing the application of its intent to do so to the
25 municipality in which it is located, the State Representative
26 and State Senator of the district in which the health care

1 facility is located, the State Board, the Director of Public
2 Health, and the Director of Healthcare and Family Services.
3 The changes made to this subsection by this amendatory Act of
4 the 101st General Assembly shall apply to all applications
5 submitted after the effective date of this amendatory Act of
6 the 101st General Assembly.

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

13 (c) (1) If there is a pending lawsuit that challenges an
14 application to discontinue a health care facility that either
15 names the Board as a party or alleges fraud in the filing of
16 the application, the Board may defer action on the application
17 for up to 6 months after the date of the initial deferral of
18 the application.

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

24 (3) The Board may defer taking final action on an
25 application to discontinue a hospital that is filed on or
26 after January 12, 2021, until the earlier to occur of: (i) the

1 expiration of the statewide disaster declaration proclaimed by
2 the Governor of the State of Illinois due to the COVID-19
3 pandemic that is in effect on January 12, 2021, or any
4 extension thereof, or July 1, 2021, whichever occurs later; or
5 (ii) the expiration of the declaration of a public health
6 emergency due to the COVID-19 pandemic as declared by the
7 Secretary of the U.S. Department of Health and Human Services
8 that is in effect on January 12, 2021, or any extension
9 thereof, or July 1, 2021, whichever occurs later. This
10 paragraph (3) is repealed as of the date of the expiration of
11 the statewide disaster declaration proclaimed by the Governor
12 of the State of Illinois due to the COVID-19 pandemic that is
13 in effect on January 12, 2021, or any extension thereof, or
14 July 1, 2021, whichever occurs later.

15 (d) The changes made to this Section by this amendatory
16 Act of the 101st General Assembly shall apply to all
17 applications submitted after the effective date of this
18 amendatory Act of the 101st General Assembly.

19 (Source: P.A. 101-83, eff. 7-15-19; 101-650, eff. 7-7-20.)

20 Title VIII. Managed Care Organization Reform

21 Article 150.

22 Section 150-5. The Illinois Public Aid Code is amended by
23 changing Section 5-30.1 as follows:

1 (305 ILCS 5/5-30.1)

2 Sec. 5-30.1. Managed care protections.

3 (a) As used in this Section:

4 "Managed care organization" or "MCO" means any entity
5 which contracts with the Department to provide services where
6 payment for medical services is made on a capitated basis.

7 "Emergency services" include:

8 (1) emergency services, as defined by Section 10 of
9 the Managed Care Reform and Patient Rights Act;

10 (2) emergency medical screening examinations, as
11 defined by Section 10 of the Managed Care Reform and
12 Patient Rights Act;

13 (3) post-stabilization medical services, as defined by
14 Section 10 of the Managed Care Reform and Patient Rights
15 Act; and

16 (4) emergency medical conditions, as defined by
17 Section 10 of the Managed Care Reform and Patient Rights
18 Act.

19 (b) As provided by Section 5-16.12, managed care
20 organizations are subject to the provisions of the Managed
21 Care Reform and Patient Rights Act.

22 (c) An MCO shall pay any provider of emergency services
23 that does not have in effect a contract with the contracted
24 Medicaid MCO. The default rate of reimbursement shall be the
25 rate paid under Illinois Medicaid fee-for-service program

1 methodology, including all policy adjusters, including but not
2 limited to Medicaid High Volume Adjustments, Medicaid
3 Percentage Adjustments, Outpatient High Volume Adjustments,
4 and all outlier add-on adjustments to the extent such
5 adjustments are incorporated in the development of the
6 applicable MCO capitated rates.

7 (d) An MCO shall pay for all post-stabilization services
8 as a covered service in any of the following situations:

9 (1) the MCO authorized such services;

10 (2) such services were administered to maintain the
11 enrollee's stabilized condition within one hour after a
12 request to the MCO for authorization of further
13 post-stabilization services;

14 (3) the MCO did not respond to a request to authorize
15 such services within one hour;

16 (4) the MCO could not be contacted; or

17 (5) the MCO and the treating provider, if the treating
18 provider is a non-affiliated provider, could not reach an
19 agreement concerning the enrollee's care and an affiliated
20 provider was unavailable for a consultation, in which case
21 the MCO must pay for such services rendered by the
22 treating non-affiliated provider until an affiliated
23 provider was reached and either concurred with the
24 treating non-affiliated provider's plan of care or assumed
25 responsibility for the enrollee's care. Such payment shall
26 be made at the default rate of reimbursement paid under

1 Illinois Medicaid fee-for-service program methodology,
2 including all policy adjusters, including but not limited
3 to Medicaid High Volume Adjustments, Medicaid Percentage
4 Adjustments, Outpatient High Volume Adjustments and all
5 outlier add-on adjustments to the extent that such
6 adjustments are incorporated in the development of the
7 applicable MCO capitated rates.

8 (e) The following requirements apply to MCOs in
9 determining payment for all emergency services:

10 (1) MCOs shall not impose any requirements for prior
11 approval of emergency services.

12 (2) The MCO shall cover emergency services provided to
13 enrollees who are temporarily away from their residence
14 and outside the contracting area to the extent that the
15 enrollees would be entitled to the emergency services if
16 they still were within the contracting area.

17 (3) The MCO shall have no obligation to cover medical
18 services provided on an emergency basis that are not
19 covered services under the contract.

20 (4) The MCO shall not condition coverage for emergency
21 services on the treating provider notifying the MCO of the
22 enrollee's screening and treatment within 10 days after
23 presentation for emergency services.

24 (5) The determination of the attending emergency
25 physician, or the provider actually treating the enrollee,
26 of whether an enrollee is sufficiently stabilized for

1 discharge or transfer to another facility, shall be
2 binding on the MCO. The MCO shall cover emergency services
3 for all enrollees whether the emergency services are
4 provided by an affiliated or non-affiliated provider.

5 (6) The MCO's financial responsibility for
6 post-stabilization care services it has not pre-approved
7 ends when:

8 (A) a plan physician with privileges at the
9 treating hospital assumes responsibility for the
10 enrollee's care;

11 (B) a plan physician assumes responsibility for
12 the enrollee's care through transfer;

13 (C) a contracting entity representative and the
14 treating physician reach an agreement concerning the
15 enrollee's care; or

16 (D) the enrollee is discharged.

17 (f) Network adequacy and transparency.

18 (1) The Department shall:

19 (A) ensure that an adequate provider network is in
20 place, taking into consideration health professional
21 shortage areas and medically underserved areas;

22 (B) publicly release an explanation of its process
23 for analyzing network adequacy;

24 (C) periodically ensure that an MCO continues to
25 have an adequate network in place; ~~and~~

26 (D) require MCOs, including Medicaid Managed Care

1 Entities as defined in Section 5-30.2, to meet
2 provider directory requirements under Section 5-30.3;
3 and -

4 (E) require MCOs to ensure that any
5 Medicaid-certified provider under contract with an MCO
6 and previously submitted on a roster on the date of
7 service is paid for any medically necessary,
8 Medicaid-covered, and authorized service rendered to
9 any of the MCO's enrollees, regardless of inclusion on
10 the MCO's published and publicly available directory
11 of available providers.

12 (2) Each MCO shall confirm its receipt of information
13 submitted specific to physician or dentist additions or
14 physician or dentist deletions from the MCO's provider
15 network within 3 days after receiving all required
16 information from contracted physicians or dentists, and
17 electronic physician and dental directories must be
18 updated consistent with current rules as published by the
19 Centers for Medicare and Medicaid Services or its
20 successor agency.

21 (g) Timely payment of claims.

22 (1) The MCO shall pay a claim within 30 days of
23 receiving a claim that contains all the essential
24 information needed to adjudicate the claim.

25 (2) The MCO shall notify the billing party of its
26 inability to adjudicate a claim within 30 days of

1 receiving that claim.

2 (3) The MCO shall pay a penalty that is at least equal
3 to the timely payment interest penalty imposed under
4 Section 368a of the Illinois Insurance Code for any claims
5 not timely paid.

6 (A) When an MCO is required to pay a timely payment
7 interest penalty to a provider, the MCO must calculate
8 and pay the timely payment interest penalty that is
9 due to the provider within 30 days after the payment of
10 the claim. In no event shall a provider be required to
11 request or apply for payment of any owed timely
12 payment interest penalties.

13 (B) Such payments shall be reported separately
14 from the claim payment for services rendered to the
15 MCO's enrollee and clearly identified as interest
16 payments.

17 (4) (A) The Department shall require MCOs to expedite
18 payments to providers identified on the Department's
19 expedited provider list, determined in accordance with 89
20 Ill. Adm. Code 140.71(b), on a schedule at least as
21 frequently as the providers are paid under the
22 Department's fee-for-service expedited provider schedule.

23 (B) Compliance with the expedited provider
24 requirement may be satisfied by an MCO through the use
25 of a Periodic Interim Payment (PIP) program that has
26 been mutually agreed to and documented between the MCO

1 and the provider, if ~~and~~ the PIP program ensures that
2 any expedited provider receives regular and periodic
3 payments based on prior period payment experience from
4 that MCO. Total payments under the PIP program may be
5 reconciled against future PIP payments on a schedule
6 mutually agreed to between the MCO and the provider.

7 (C) The Department shall share at least monthly
8 its expedited provider list and the frequency with
9 which it pays providers on the expedited list.

10 (g-5) Recognizing that the rapid transformation of the
11 Illinois Medicaid program may have unintended operational
12 challenges for both payers and providers:

13 (1) in no instance shall a medically necessary covered
14 service rendered in good faith, based upon eligibility
15 information documented by the provider, be denied coverage
16 or diminished in payment amount if the eligibility or
17 coverage information available at the time the service was
18 rendered is later found to be inaccurate in the assignment
19 of coverage responsibility between MCOs or the
20 fee-for-service system, except for instances when an
21 individual is deemed to have not been eligible for
22 coverage under the Illinois Medicaid program; and

23 (2) the Department shall, by December 31, 2016, adopt
24 rules establishing policies that shall be included in the
25 Medicaid managed care policy and procedures manual
26 addressing payment resolutions in situations in which a

1 provider renders services based upon information obtained
2 after verifying a patient's eligibility and coverage plan
3 through either the Department's current enrollment system
4 or a system operated by the coverage plan identified by
5 the patient presenting for services:

6 (A) such medically necessary covered services
7 shall be considered rendered in good faith;

8 (B) such policies and procedures shall be
9 developed in consultation with industry
10 representatives of the Medicaid managed care health
11 plans and representatives of provider associations
12 representing the majority of providers within the
13 identified provider industry; and

14 (C) such rules shall be published for a review and
15 comment period of no less than 30 days on the
16 Department's website with final rules remaining
17 available on the Department's website.

18 The rules on payment resolutions shall include, but not be
19 limited to:

20 (A) the extension of the timely filing period;

21 (B) retroactive prior authorizations; and

22 (C) guaranteed minimum payment rate of no less than
23 the current, as of the date of service, fee-for-service
24 rate, plus all applicable add-ons, when the resulting
25 service relationship is out of network.

26 The rules shall be applicable for both MCO coverage and

1 fee-for-service coverage.

2 If the fee-for-service system is ultimately determined to
3 have been responsible for coverage on the date of service, the
4 Department shall provide for an extended period for claims
5 submission outside the standard timely filing requirements.

6 (g-6) MCO Performance Metrics Report.

7 (1) The Department shall publish, on at least a
8 quarterly basis, each MCO's operational performance,
9 including, but not limited to, the following categories of
10 metrics:

11 (A) claims payment, including timeliness and
12 accuracy;

13 (B) prior authorizations;

14 (C) grievance and appeals;

15 (D) utilization statistics;

16 (E) provider disputes;

17 (F) provider credentialing; and

18 (G) member and provider customer service.

19 (2) The Department shall ensure that the metrics
20 report is accessible to providers online by January 1,
21 2017.

22 (3) The metrics shall be developed in consultation
23 with industry representatives of the Medicaid managed care
24 health plans and representatives of associations
25 representing the majority of providers within the
26 identified industry.

1 (4) Metrics shall be defined and incorporated into the
2 applicable Managed Care Policy Manual issued by the
3 Department.

4 (g-7) MCO claims processing and performance analysis. In
5 order to monitor MCO payments to hospital providers, pursuant
6 to this amendatory Act of the 100th General Assembly, the
7 Department shall post an analysis of MCO claims processing and
8 payment performance on its website every 6 months. Such
9 analysis shall include a review and evaluation of a
10 representative sample of hospital claims that are rejected and
11 denied for clean and unclean claims and the top 5 reasons for
12 such actions and timeliness of claims adjudication, which
13 identifies the percentage of claims adjudicated within 30, 60,
14 90, and over 90 days, and the dollar amounts associated with
15 those claims. The Department shall post the contracted claims
16 report required by HealthChoice Illinois on its website every
17 3 months.

18 (g-8) Dispute resolution process. The Department shall
19 maintain a provider complaint portal through which a provider
20 can submit to the Department unresolved disputes with an MCO.
21 An unresolved dispute means an MCO's decision that denies in
22 whole or in part a claim for reimbursement to a provider for
23 health care services rendered by the provider to an enrollee
24 of the MCO with which the provider disagrees. Disputes shall
25 not be submitted to the portal until the provider has availed
26 itself of the MCO's internal dispute resolution process.

1 Disputes that are submitted to the MCO internal dispute
2 resolution process may be submitted to the Department of
3 Healthcare and Family Services' complaint portal no sooner
4 than 30 days after submitting to the MCO's internal process
5 and not later than 30 days after the unsatisfactory resolution
6 of the internal MCO process or 60 days after submitting the
7 dispute to the MCO internal process. Multiple claim disputes
8 involving the same MCO may be submitted in one complaint,
9 regardless of whether the claims are for different enrollees,
10 when the specific reason for non-payment of the claims
11 involves a common question of fact or policy. Within 10
12 business days of receipt of a complaint, the Department shall
13 present such disputes to the appropriate MCO, which shall then
14 have 30 days to issue its written proposal to resolve the
15 dispute. The Department may grant one 30-day extension of this
16 time frame to one of the parties to resolve the dispute. If the
17 dispute remains unresolved at the end of this time frame or the
18 provider is not satisfied with the MCO's written proposal to
19 resolve the dispute, the provider may, within 30 days, request
20 the Department to review the dispute and make a final
21 determination. Within 30 days of the request for Department
22 review of the dispute, both the provider and the MCO shall
23 present all relevant information to the Department for
24 resolution and make individuals with knowledge of the issues
25 available to the Department for further inquiry if needed.
26 Within 30 days of receiving the relevant information on the

1 dispute, or the lapse of the period for submitting such
2 information, the Department shall issue a written decision on
3 the dispute based on contractual terms between the provider
4 and the MCO, contractual terms between the MCO and the
5 Department of Healthcare and Family Services and applicable
6 Medicaid policy. The decision of the Department shall be
7 final. By January 1, 2020, the Department shall establish by
8 rule further details of this dispute resolution process.
9 Disputes between MCOs and providers presented to the
10 Department for resolution are not contested cases, as defined
11 in Section 1-30 of the Illinois Administrative Procedure Act,
12 conferring any right to an administrative hearing.

13 (g-9)(1) The Department shall publish annually on its
14 website a report on the calculation of each managed care
15 organization's medical loss ratio showing the following:

16 (A) Premium revenue, with appropriate adjustments.

17 (B) Benefit expense, setting forth the aggregate
18 amount spent for the following:

19 (i) Direct paid claims.

20 (ii) Subcapitation payments.

21 (iii) Other claim payments.

22 (iv) Direct reserves.

23 (v) Gross recoveries.

24 (vi) Expenses for activities that improve health
25 care quality as allowed by the Department.

26 (2) The medical loss ratio shall be calculated consistent

1 with federal law and regulation following a claims runout
2 period determined by the Department.

3 (g-10)(1) "Liability effective date" means the date on
4 which an MCO becomes responsible for payment for medically
5 necessary and covered services rendered by a provider to one
6 of its enrollees in accordance with the contract terms between
7 the MCO and the provider. The liability effective date shall
8 be the later of:

9 (A) The execution date of a network participation
10 contract agreement.

11 (B) The date the provider or its representative
12 submits to the MCO the complete and accurate standardized
13 roster form for the provider in the format approved by the
14 Department.

15 (C) The provider effective date contained within the
16 Department's provider enrollment subsystem within the
17 Illinois Medicaid Program Advanced Cloud Technology
18 (IMPACT) System.

19 (2) The standardized roster form may be submitted to the
20 MCO at the same time that the provider submits an enrollment
21 application to the Department through IMPACT.

22 (3) By October 1, 2019, the Department shall require all
23 MCOs to update their provider directory with information for
24 new practitioners of existing contracted providers within 30
25 days of receipt of a complete and accurate standardized roster
26 template in the format approved by the Department provided

1 that the provider is effective in the Department's provider
2 enrollment subsystem within the IMPACT system. Such provider
3 directory shall be readily accessible for purposes of
4 selecting an approved health care provider and comply with all
5 other federal and State requirements.

6 (g-11) The Department shall work with relevant
7 stakeholders on the development of operational guidelines to
8 enhance and improve operational performance of Illinois'
9 Medicaid managed care program, including, but not limited to,
10 improving provider billing practices, reducing claim
11 rejections and inappropriate payment denials, and
12 standardizing processes, procedures, definitions, and response
13 timelines, with the goal of reducing provider and MCO
14 administrative burdens and conflict. The Department shall
15 include a report on the progress of these program improvements
16 and other topics in its Fiscal Year 2020 annual report to the
17 General Assembly.

18 (g-12) Notwithstanding any other provision of law, if the
19 Department or an MCO requires submission of a claim for
20 payment in a non-electronic format, a provider shall always be
21 afforded a period of no less than 90 business days, as a
22 correction period, following any notification of rejection by
23 either the Department or the MCO to correct errors or
24 omissions in the original submission.

25 Under no circumstances, either by an MCO or under the
26 State's fee-for-service system, shall a provider be denied

1 payment for failure to comply with any timely submission
2 requirements under this Code or under any existing contract,
3 unless the non-electronic format claim submission occurs after
4 the initial 180 days following the latest date of service on
5 the claim, or after the 90 business days correction period
6 following notification to the provider of rejection or denial
7 of payment.

8 (h) The Department shall not expand mandatory MCO
9 enrollment into new counties beyond those counties already
10 designated by the Department as of June 1, 2014 for the
11 individuals whose eligibility for medical assistance is not
12 the seniors or people with disabilities population until the
13 Department provides an opportunity for accountable care
14 entities and MCOs to participate in such newly designated
15 counties.

16 (i) The requirements of this Section apply to contracts
17 with accountable care entities and MCOs entered into, amended,
18 or renewed after June 16, 2014 (the effective date of Public
19 Act 98-651).

20 (j) Health care information released to managed care
21 organizations. A health care provider shall release to a
22 Medicaid managed care organization, upon request, and subject
23 to the Health Insurance Portability and Accountability Act of
24 1996 and any other law applicable to the release of health
25 information, the health care information of the MCO's
26 enrollee, if the enrollee has completed and signed a general

1 release form that grants to the health care provider
2 permission to release the recipient's health care information
3 to the recipient's insurance carrier.

4 (k) The Department of Healthcare and Family Services,
5 managed care organizations, a statewide organization
6 representing hospitals, and a statewide organization
7 representing safety-net hospitals shall explore ways to
8 support billing departments in safety-net hospitals.

9 (l) The requirements of this Section added by this
10 amendatory Act of the 102nd General Assembly shall apply to
11 services provided on or after the first day of the month that
12 begins 60 days after the effective date of this amendatory Act
13 of the 102nd General Assembly.

14 (Source: P.A. 100-201, eff. 8-18-17; 100-580, eff. 3-12-18;
15 100-587, eff. 6-4-18; 101-209, eff. 8-5-19.)

16 Article 155.

17 Section 155-5. The Illinois Public Aid Code is amended by
18 adding Section 5-30.17 as follows:

19 (305 ILCS 5/5-30.17 new)

20 Sec. 5-30.17. Medicaid Managed Care Oversight Commission.

21 (a) The Medicaid Managed Care Oversight Commission is
22 created within the Department of Healthcare and Family
23 Services to evaluate the effectiveness of Illinois' managed

1 care program.

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

3 (1) One member of the Senate, appointed by the Senate
4 President, who shall serve as co-chair.

5 (2) One member of the House of Representatives,
6 appointed by the Speaker of the House of Representatives,
7 who shall serve as co-chair.

8 (3) One member of the House of Representatives,
9 appointed by the Minority Leader of the House of
10 Representatives.

11 (4) One member of the Senate, appointed by the Senate
12 Minority Leader.

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

15 (6) One member representing the Department of Public
16 Health, appointed by the Governor.

17 (7) One member representing the Department of Human
18 Services, appointed by the Governor.

19 (8) One member representing the Department of Children
20 and Family Services, appointed by the Governor.

21 (9) One member of a statewide association representing
22 Medicaid managed care plans, appointed by the Governor.

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

26 (11) Two academic experts on Medicaid managed care

1 programs, appointed by the Governor.

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

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

8 (14) Members representing Federally Qualified Health
9 Centers, a long-term care association, a dental
10 association, pharmacies, pharmacists, a developmental
11 disability association, a Medicaid consumer advocate, a
12 Medicaid consumer, an association representing physicians,
13 a behavioral health association, and an association
14 representing pediatricians, appointed by the Governor.

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

17 (c) The Director of Healthcare and Family Services and
18 chief of staff, or their designees, shall serve as the
19 Commission's executive administrators in providing
20 administrative support, research support, and other
21 administrative tasks requested by the Commission's co-chairs.
22 Any expenses, including, but not limited to, travel and
23 housing, shall be paid for by the Department's existing
24 budget.

25 (d) The members of the Commission shall receive no
26 compensation for their services as members of the Commission.

1 (e) The Commission shall meet quarterly beginning as soon
2 as is practicable after the effective date of this amendatory
3 Act of the 102nd General Assembly.

4 (f) The Commission shall:

5 (1) review data on health outcomes of Medicaid managed
6 care members;

7 (2) review current care coordination and case
8 management efforts and make recommendations on expanding
9 care coordination to additional populations with a focus
10 on the social determinants of health;

11 (3) review and assess the appropriateness of metrics
12 used in the Pay-for-Performance programs;

13 (4) review the Department's prior authorization and
14 utilization management requirements and recommend
15 adaptations for the Medicaid population;

16 (5) review managed care performance in meeting
17 diversity contracting goals and the use of funds dedicated
18 to meeting such goals, including, but not limited to,
19 contracting requirements set forth in the Business
20 Enterprise for Minorities, Women, and Persons with
21 Disabilities Act; recommend strategies to increase
22 compliance with diversity contracting goals in
23 collaboration with the Chief Procurement Officer for
24 General Services and the Business Enterprise Council for
25 Minorities, Women, and Persons with Disabilities; and
26 recoup any misappropriated funds for diversity

1 contracting;

2 (6) review data on the effectiveness of processing to
3 medical providers;

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

6 (8) review value-based and other alternative payment
7 methodologies to make recommendations to enhance program
8 efficiency and improve health outcomes;

9 (9) review the compliance of all managed care entities
10 in State contracts and recommend reasonable financial
11 penalties for any noncompliance;

12 (10) produce an annual report detailing the
13 Commission's findings based upon its review of research
14 conducted under this Section, including specific
15 recommendations, if any, and any other information the
16 Commission may deem proper in furtherance of its duties
17 under this Section;

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

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

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

1 safety-net hospitals.

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

5 (g) Beginning January 1, 2022, and for each year
6 thereafter, the Commission shall submit a report of its
7 findings and recommendations to the General Assembly. The
8 report to the General Assembly shall be filed with the Clerk of
9 the House of Representatives and the Secretary of the Senate
10 in electronic form only, in the manner that the Clerk and the
11 Secretary shall direct.

12 Article 160.

13 Section 160-5. The State Finance Act is amended by adding
14 Sections 5.935 and 6z-124 as follows:

15 (30 ILCS 105/5.935 new)

16 Sec. 5.935. The Managed Care Oversight Fund.

17 (30 ILCS 105/6z-124 new)

18 Sec. 6z-124. Managed Care Oversight Fund. The Managed Care
19 Oversight Fund is created as a special fund in the State
20 treasury. Subject to appropriation, available annual moneys in
21 the Fund shall be used by the Department of Healthcare and
22 Family Services to support contracting with women and

1 minority-owned businesses as part of the Department's Business
2 Enterprise Program requirements. The Department shall
3 prioritize contracts for care coordination services, workforce
4 development, and other services that support the Department's
5 mission to promote health equity. Funds may not be used for any
6 administrative costs of the Department.

7 Article 170.

8 Section 170-5. The Illinois Public Aid Code is amended by
9 adding Section 5-30.16 as follows:

10 (305 ILCS 5/5-30.16 new)

11 Sec. 5-30.16. Medicaid Business Opportunity Commission.

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

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

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

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

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

23 (4) Two members representing a statewide Medicaid

1 health plan association, appointed by the Governor.

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

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

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

9 (8) One member representing the Business Enterprise
10 Council, appointed by the Governor.

11 (c) The Director of Healthcare and Family Services and
12 chief of staff, or their designees, shall serve as the
13 Commission's executive administrators in providing
14 administrative support, research support, and other
15 administrative tasks requested by the Commission's co-chairs.
16 Any expenses, including, but not limited to, travel and
17 housing, shall be paid for by the Department's existing
18 budget.

19 (d) The members of the Commission shall receive no
20 compensation for their services as members of the Commission.

21 (e) The members of the Commission shall designate
22 co-chairs of the Commission to lead their efforts at the first
23 meeting of the Commission.

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

1 (g) The Commission shall:

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

8 (2) Make recommendations on the process by which
9 vendors or providers would be certified as eligible to be
10 included in the program and appropriate eligibility
11 standards relative to the healthcare industry.

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

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

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

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

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

5 (i) Beginning January 1, 2022, and for each year
6 thereafter, the Commission shall submit a report of its
7 findings and recommendations to the General Assembly. The
8 report to the General Assembly shall be filed with the Clerk of
9 the House of Representatives and the Secretary of the Senate
10 in electronic form only, in the manner that the Clerk and the
11 Secretary shall direct.

12 Article 172.

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

15 (305 ILCS 5/14-13)

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

18 (a) By October 1, 2019, the Department shall by rule
19 implement a methodology effective for dates of service July 1,
20 2019 and later to reimburse hospitals for inpatient stays
21 extended beyond medical necessity due to the inability of the
22 Department or the managed care organization in which a
23 recipient is enrolled or the hospital discharge planner to

1 find an appropriate placement after discharge from the
2 hospital. The Department shall evaluate the effectiveness of
3 the current reimbursement rate for inpatient hospital stays
4 beyond medical necessity.

5 (b) The methodology shall provide reasonable compensation
6 for the services provided attributable to the days of the
7 extended stay for which the prevailing rate methodology
8 provides no reimbursement. The Department may use a day
9 outlier program to satisfy this requirement. The reimbursement
10 rate shall be set at a level so as not to act as an incentive
11 to avoid transfer to the appropriate level of care needed or
12 placement, after discharge.

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

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

24 (e) For services covered by the fee-for-service program,
25 reimbursement under this Section shall only be made for days
26 beyond medical necessity that occur after the hospital has

1 notified the Department of the need for post-discharge
2 placement. For services covered by a managed care
3 organization, hospitals shall notify the appropriate managed
4 care organization of an admission within 24 hours of
5 admission. For every 24-hour period beyond the initial 24
6 hours after admission that the hospital fails to notify the
7 managed care organization of the admission, reimbursement
8 under this subsection shall be reduced by one day.

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

10 Title IX. Maternal and Infant Mortality

11 Article 175.

12 Section 175-5. The Illinois Public Aid Code is amended by
13 adding Section 5-18.5 as follows:

14 (305 ILCS 5/5-18.5 new)

15 Sec. 5-18.5. Perinatal doula and evidence-based home
16 visiting services.

17 (a) As used in this Section:

18 "Home visiting" means a voluntary, evidence-based strategy
19 used to support pregnant people, infants, and young children
20 and their caregivers to promote infant, child, and maternal
21 health, to foster educational development and school
22 readiness, and to help prevent child abuse and neglect. Home

1 visitors are trained professionals whose visits and activities
2 focus on promoting strong parent-child attachment to foster
3 healthy child development.

4 "Perinatal doula" means a trained provider who provides
5 regular, voluntary physical, emotional, and educational
6 support, but not medical or midwife care, to pregnant and
7 birthing persons before, during, and after childbirth,
8 otherwise known as the perinatal period.

9 "Perinatal doula training" means any doula training that
10 focuses on providing support throughout the prenatal, labor
11 and delivery, or postpartum period, and reflects the type of
12 doula care that the doula seeks to provide.

13 (b) Notwithstanding any other provision of this Article,
14 perinatal doula services and evidence-based home visiting
15 services shall be covered under the medical assistance
16 program, subject to appropriation, for persons who are
17 otherwise eligible for medical assistance under this Article.
18 Perinatal doula services include regular visits beginning in
19 the prenatal period and continuing into the postnatal period,
20 inclusive of continuous support during labor and delivery,
21 that support healthy pregnancies and positive birth outcomes.
22 Perinatal doula services may be embedded in an existing
23 program, such as evidence-based home visiting. Perinatal doula
24 services provided during the prenatal period may be provided
25 weekly, services provided during the labor and delivery period
26 may be provided for the entire duration of labor and the time

1 immediately following birth, and services provided during the
2 postpartum period may be provided up to 12 months postpartum.

3 (c) The Department of Healthcare and Family Services shall
4 adopt rules to administer this Section. In this rulemaking,
5 the Department shall consider the expertise of and consult
6 with doula program experts, doula training providers,
7 practicing doulas, and home visiting experts, along with State
8 agencies implementing perinatal doula services and relevant
9 bodies under the Illinois Early Learning Council. This body of
10 experts shall inform the Department on the credentials
11 necessary for perinatal doula and home visiting services to be
12 eligible for Medicaid reimbursement and the rate of
13 reimbursement for home visiting and perinatal doula services
14 in the prenatal, labor and delivery, and postpartum periods.
15 Every 2 years, the Department shall assess the rates of
16 reimbursement for perinatal doula and home visiting services
17 and adjust rates accordingly.

18 (d) The Department shall seek such State plan amendments
19 or waivers as may be necessary to implement this Section and
20 shall secure federal financial participation for expenditures
21 made by the Department in accordance with this Section.

22 Title X.Medicaid Managed Care Reform

23 Article 185.

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

4 Section 185-3. Findings. The General Assembly finds as
5 follows:

6 (1) This Act seeks to remedy a fraction of a much
7 larger broken system by addressing access to health care,
8 managed care organization reform, mental and substance
9 abuse treatment services, and services to address the
10 social determinants of health.

11 (2) Illinois transitioned Medicaid services to managed
12 care with the goals of achieving better health outcomes
13 for the Medicaid population and reducing the per capita
14 costs of health care.

15 (3) Illinois benefits when people have support
16 constructing the sturdy foundation of health and
17 well-being that we all need to reach our potential.
18 Medicaid managed care can be a vital tool in ensuring that
19 people have the full range of supports that form this
20 foundation, including services from community providers
21 that address behavioral health needs, as well as related
22 services that help people access food, housing, and
23 employment.

24 (4) However, there are barriers that prevent Illinois
25 from fully realizing the benefits of Medicaid managed

1 care. The 2 devastating years of the State budget impasse
2 resulted in 2 years of lost opportunity for community
3 providers to invest in the people, systems, and technology
4 that are necessary for them to participate in Medicaid
5 managed care. A recent survey by the Illinois
6 Collaboration on Youth of more than 130 community
7 providers revealed that the majority do not have contracts
8 with managed care organizations, and most do not have
9 adequate billing and technology infrastructure sufficient
10 for Medicaid billing now or in the future. The survey also
11 revealed that community-based providers primarily serving
12 people of color are the least prepared to participate in
13 Medicaid managed care.

14 (5) The disparity in readiness between providers
15 primarily serving people of color and those who serve a
16 more mixed or white clientele is especially urgent because
17 62% of Illinois' Medicaid recipients are people of color.
18 Racial disparities in behavioral health care result in
19 significant human and financial costs to both the
20 individual and to the State.

21 (6) The COVID-19 pandemic has further exacerbated the
22 health disparities experienced by communities of color.
23 COVID-19 has increased both the Medicaid-eligible
24 population in Illinois, and increased the demand for
25 behavioral health services, as Illinois residents grapple
26 with trauma, death, job loss, depression, suicide,

1 addiction, and exposure to violence. In addition, COVID-19
2 threatens the stability and viability of community-based
3 providers, further straining the health care safety net
4 for people who depend on Medicaid for these essential
5 services.

6 (7) Lack of support for a diversity of providers
7 reduces choice for Medicaid recipients and may incentivize
8 managed care organizations to focus on a narrow selection
9 of community partners. Having some choice in which
10 providers people see for these essential services and
11 having access to providers who understand their community,
12 culture, and language has been demonstrated to reduce
13 disparities in health outcomes and improve health and
14 well-being across the life span.

15 (8) The Medicaid managed care system lacks consistent,
16 statewide support for community providers, creating
17 inefficiency and duplication. Providers need targeted
18 trainings focused on their levels of readiness, learning
19 collaboratives to provide group-level support for those
20 experiencing similar challenges, and a mechanism to
21 identify problems that need systemic solutions. Illinois
22 could receive up to 70% in Medicaid matching funds from
23 the federal government to supplement the costs of
24 operating a Medicaid Technical Assistance Center.

25 (9) When community-based health care providers are
26 able to contract with managed care organizations to

1 deliver Medicaid services, people can access the care they
2 need, in their communities, from providers they trust.

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

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

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

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

11 "Health equity" means providing care that does not vary in
12 quality because of personal characteristics such as gender,
13 ethnicity, geographic location, and socioeconomic status.

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

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

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

24 "Stakeholders" means, but are not limited to, health care
25 providers, advocacy organizations, managed care organizations,

1 Medicaid beneficiaries, and State and city partners.

2 Section 185-10. Medicaid Technical Assistance Center. The
3 Department of Healthcare and Family Services shall establish a
4 Medicaid Technical Assistance Center. The Medicaid Technical
5 Assistance Center shall operate as a cross-system educational
6 resource to strengthen the business infrastructure of health
7 care provider organizations in Illinois to ultimately increase
8 the capacity, access, health equity, and quality of Illinois'
9 Medicaid managed care program, HealthChoice Illinois, and
10 YouthCare, the Medicaid managed care program for children and
11 youth who receive Medicaid health services through the
12 Department of Children and Family Services. The Medicaid
13 Technical Assistance Center shall be established within the
14 Department's Office of Medicaid Innovation.

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

22 (1) Outreach and engagement: The Medicaid Technical
23 Assistance Center shall undertake efforts to identify and
24 engage community-based providers offering behavioral

1 health services or services addressing the social
2 determinants of health, especially those predominantly
3 serving communities of color or those operating within or
4 near service deserts, for the purpose of offering training
5 and technical assistance to them through the Medicaid
6 Technical Assistance Center. Outreach and engagement
7 services may be subcontracted.

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

19 (3) Web-based resources: The Medicaid Technical
20 Assistance Center shall maintain an independent, easy to
21 navigate, and up-to-date website that includes, but is not
22 limited to: recorded training archives, a training
23 calendar, provider resources and tools, up-to-date
24 explanations of Department and managed care organization
25 guidance, a running database of frequently asked questions
26 and contact information for key staff members of the

1 Department, managed care organizations, and the Medicaid
2 Technical Assistance Center.

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

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

17 (6) Equitable delivery system: The Medicaid Technical
18 Assistance Center is committed to the principle that all
19 Medicaid recipients have accessible and equitable physical
20 and mental health care services. All providers served
21 through the Medicaid Technical Assistance Center shall
22 deliver services notwithstanding the patient's race,
23 color, gender, gender identity, age, ancestry, marital
24 status, military status, religion, national origin,
25 disability status, sexual orientation, order of protection
26 status, as defined under Section 1-103 of the Illinois

1 Human Rights Act, or immigration status.

2 Section 185-20. Federal financial participation. The
3 Department of Healthcare and Family Services, to the extent
4 allowable under federal law, shall maximize federal financial
5 participation for any moneys appropriated to the Department
6 for the Medicaid Technical Assistance Center. Any federal
7 financial participation funds obtained in accordance with this
8 Section shall be used for the further development and
9 expansion of the Medicaid Technical Assistance Center. All
10 federal financial participation funds obtained under this
11 subsection shall be deposited into the Medicaid Technical
12 Assistance Center Fund created under Section 25.

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

23 Section 185-90. The State Finance Act is amended by adding

1 Section 5.935 as follows:

2 (30 ILCS 105/5.935 new)

3 Sec. 5.935. The Medicaid Technical Assistance Center Fund.

4 Title XI.Miscellaneous

5 Article 999.

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