IHA Overview of General Assembly’s Spring 2019 Session

Considering the volatile political environment and the many challenges IHA and the hospital community faced, by staying united and speaking with a unified voice, we were able to achieve many notable successes in the Spring 2019 session of the Illinois General Assembly. Those successes include: Medicaid managed care reforms, no Medicaid cuts, no mandatory nurse staffing ratios, a $200 million Hospital and Healthcare Transformation Capital Investment Grant Program, compromise legislation to mitigate potential harmful changes to the Certificate of Need Program, a five-year extension of the sales tax exemption for nonprofit hospitals, and a $55 million correction in the Outpatient Assessment rates for Critical Access Hospitals.

Beyond these important, high-profile issues, during the course of the session, IHA worked on your behalf to closely track and influence hundreds of other bills and issues – successfully opposing or favorably modifying bills that would have imposed unnecessary or onerous burdens or requirements on hospitals and health systems.

We greatly appreciate the strong support and advocacy of our members that enabled IHA and the hospital community to work together to address the many difficult issues we faced during the legislative session. We are pleased to provide this detailed overview of the key bills that IHA worked on to ensure the best possible outcomes for the hospital community.

Budget and Finances

**SB262/PA101-0007** (President John Cullerton/Rep. Greg Harris)
**SB689/PA 101-0009** (Sen. Toi Hutchinson/Rep. Greg Harris)

FY2020 State Budget

**SB262 Enacted and Effective June 5, 2019, some provisions effective July 1, 2019**
**SB689 and SB1814 Enacted and Effective June 5, 2019**

This package of bills represents the FY2020 Illinois State Budget. The $40 billion state appropriation includes no Medicaid rate cuts, and a $3 million appropriation for the Illinois Poison Center. The state budget is partly funded by an MCO tax which IHA supported.

Other important budget items:
- An increase in the hospital assessment tax that had been scheduled to take effect this July 1 to cover increased state costs related to declining ACA federal matching rates has been delayed by one year, saving hospitals $12.5 million.
- $1.2 billion in bonding is included to help pay down the state’s multi-billion dollar backlog of unpaid bills.
• No reductions in the prompt pay interest rate. IHA blocked proposals – including SB2057 – to significantly decrease (by as much as 75%) the prompt pay interest penalty that the state pays to providers, including hospitals.

• $500,000 is appropriated for the Medical Licensing Division of the Illinois Department of Financial and Professional Regulation to hire additional staff for timelier processing of licenses for physicians and other healthcare professionals, which IHA advocated for.

• Although not part of IHA’s advocacy agenda, the final budget includes an assortment of appropriations for specific hospitals championed by individual legislators. These healthcare earmarks, along with a significant number of earmarks throughout other sectors of the state budget, were added late in the process as part of final budget negotiations between the legislative caucuses and the Governor’s Office.

SB1469/PA100-1181 (Sen. Heather Steans/Rep. Greg Harris)
Nonprofit Hospital Sales Tax Exemption and Critical Access Hospital Assessment Rates
Effective March 8, 2019
In early March, Governor Pritzker signed IHA-backed legislation to: 1) extend the sunset on nonprofit hospital sales tax exemptions to July 1, 2022 and retroactively validate any previous sales tax exemptions granted under the 2012 hospital property and sales tax exemption law; 2) direct the Department of Healthcare and Family Services (HFS) to make a $55 million correction in the Outpatient rates retroactive to July 1, 2018 for all Critical Access Hospitals, and to prospectively adjust the rates for non-CAHs, to reflect the model authorized in the spring 2018 legislation for the redesigned Hospital Assessment Program.

HB62/PA101-0029 (Rep. Greg Harris/President John Cullerton)
SB690/PA101-0031 (Sen. Terry Link/Rep. Bob Rita)
HB62 Effective July 1, 2019
HB142 Enacted and effective June 28, 2019
SB690 Enacted June 28, 2019, some provisions effective January 1, 2020
Hospital and Healthcare Transformation Capital Investment Grant Program
The General Assembly passed a major capital infrastructure program, which includes $200 million for the Hospital and Healthcare Transformation Capital Investment Grant Program. This program will be established by the Capital Development Board, in coordination with the Department of Healthcare and Family Services (HFS). Under this program, grants will be awarded on a competitive basis to hospitals and other healthcare providers. Utilizing data available to it, HFS will establish standards for determining the priority of needs concerning healthcare transformation based on projects located in communities with the greatest utilization of Medicaid services or underserved communities, including, but not limited to, Safety Net Hospitals and Critical Access Hospitals. This program is substantially similar to IHA’s proposal for a Hospital Transformation Capital Program, so we greatly appreciate the Governor and General Assembly embracing this proposal. Revenues to fund the capital program include a $1/pack cigarette increase, which was supported by IHA, and sports betting and a major expansion of gaming.
**SB2057** (Sen. Laura Murphy) – Lowers the Prompt Payment Penalty  
Re-Referred to Assignments Committee

This legislation would have reduced the prompt payment penalty the state pays to providers when the state does not pay its bills on time. The legislation would have provided that any bill approved for payment to a service provider on or after July 1, 2019 is subject to a reduced interest payment penalty if the bill is not paid within 90 days. This legislation would have greatly reduced the prompt payment penalty by 75% from the current 12% annually to the greater of 3% annually or twice the CPI increase from the previous year. Strongly opposed by IHA and other state service providers, after months of discussion, the bill did not advance.

**Cannabis**

Effective June 25, 2019

This bill legalizes recreational marijuana, and includes protections permitting employers to adopt reasonable zero tolerance or drug free workplace policies, and policies concerning drug testing, smoking, consumption, storage, or use of cannabis in the workplace or while on call. Additionally, nothing in the bill requires an employer to permit an employee to be under the influence of or use cannabis in the workplace or while performing their job duties or while on call and an employer may discipline an employee or terminate an employee’s employment for violating the employer’s workplace drug policies. Find a summary [here](#) of the bill’s major provisions.

Effective August 8, 2019

This legislation will expand the Compassionate Use of Medical Cannabis Pilot Program in several ways: 1) it will make this pilot program permanent; 2) it will allow licensed advanced practice registered nurses and physician assistants (in addition to physicians) to certify patients with a qualifying condition; and 3) it will add 11 conditions to the approved list of permitted medical use allowances as recommended by the Medical Cannabis Advisory Board. The following conditions will now be considered qualifying conditions: (i) autism; (ii) chronic pain; (iii) irritable bowel syndrome; (iv) migraines; (v) osteoarthritis; (vi) anorexia nervosa; (vii) Ehlers-Danlos Syndrome; (viii) Neuro-Behcet's Autoimmune Disease; (ix) neuropathy; (x) polycystic kidney disease; and (xi) superior canal dehiscence syndrome. IHA will provide members a more detailed summary of this legislation.

**Insurance**

**HB2160/PA101-0463** (Rep. Deb Conroy) – Drugs-Prior Authorization Form  
Effective Jan. 1, 2020

This legislation requires the Department of Healthcare and Family Services (HFS) and the Department of Insurance (DOI) to develop uniform electronic prior authorization forms for prescription drugs by July 1, 2020. The DOI form must be accepted by insurers that provide prescription drug coverage and are subject to the Illinois Insurance Code, and the HFS form by
Medicaid Managed Care Organizations (MCOs) as of July 1, 2021. If an insurer does not respond to a prior authorization request submitted on the standard form within 72 hours (or 24 hours for an expedited request), the authorization is to be deemed granted. If an MCO does not respond to a prior authorization request with 24 hours, then the authorization is deemed granted. This legislation could serve as a precedent for standardization of prior authorization processes for hospital services. A similar bill passed both chambers during the 100st General Assembly but was vetoed by Governor Rauner.

**SB1321**/PA101-0209 (Sen. Heather Steans/Rep. Greg Harris) Medicaid Managed Care Reforms Effective August 5, 2019

This comprehensive legislative package, which was the result of intense advocacy and negotiation by IHA over the past several months, lays the foundation for reducing inappropriate payment denials and significantly easing administrative burdens on hospitals and health systems. Key provisions include: (1) reimbursement for stays beyond medical necessity; (2) expedited payments; (3) timely payment interest penalties; (4) a dispute resolution process; (5) claims rejection/denial management; (6) timely filing extension for eligibility errors; (7) provider effective dates; (8) provider directory updates; (9) operational standardization; (10) transparency related to medical loss ratios; and (11) value-based payment models. Click here for a technical summary of this comprehensive legislation.


Originally intended to close a loophole in state law to ensure parity between benefits and payment limitations for behavioral health conditions and other medical conditions covered by disability insurers, this legislation was negotiated with the insurance industry to mandate the Illinois Department of Insurance to create a task force that analyzes the issue. The task force will be made up of state legislators, disability insurers, experts in the behavioral health treatment industry and consumers. The task force must examine the use of disability insurance for behavioral health conditions and submit findings and recommendations on the economic feasibility and cost effectiveness of providing behavioral health benefits to the Governor by December 31, 2020.

**HB207** (Rep. Mary Flowers) – Health Care for All

Re-referred to Rules Committee

This bill would have provided that all Illinois residents are covered under a new state health plan entitled to receive primary care, inpatient and outpatient care, prescriptions, durable medical equipment, long-term care, dental and vision services with no deductibles or copays. Investor-owned hospitals would be outlawed and investor-owned HMOs and group practices would be converted to nonprofits. The sale of health insurance that duplicates the benefits provided under the Act would be outlawed. Hospitals would have been paid a lump sum to cover expenses based on annual negotiations with a Board formed to administer the program. Funding for the program would have come from state appropriations and graduated income tax contributions from individuals, businesses and the government. The bill was opposed by many, including IHA, and the bill did not advance.
**HB3055** (Rep. Jaime Andrade) – Medicaid Managed Care  
Re-referred to Rules Committee  
An initiative of the Illinois Association of Medicaid Health Plans (IAMHP), this bill would have limited Medicaid Managed Care Organization (MCO) reimbursement for medical services, other than emergency and post-stabilization services, rendered by an out-of-network hospital to 90 percent of the Medicaid fee-for-service (FFS) rate if the hospital and MCO were unable to reach a contract agreement. This reimbursement ceiling would apply regardless of the contract terms offered by the MCO. IHA strongly opposed this bill because it would give the MCOs extraordinary leverage in contract negotiations, essentially allowing them to default to 90 percent of the FFS rate without negotiating in good faith.

**SB1187** (Sen. Jim Oberweis) – Right to Shop Act  
Re-referred to Assignments Committee  
This bill would have required carriers offering health benefits in Illinois to develop and implement programs that provide incentives for enrollees seeking healthcare services from the lowest cost provider. The incentives ranged from cash rebates to gift cards to credits for enrollee’s deductibles or out-of-pocket costs. While IHA supports transparency of pricing, focusing exclusively on cost when seeking medical care does not take into account physician experience, expertise or other factors related to quality of care and does nothing to increase price transparency, lower healthcare costs or generate improved quality outcomes. This proposed model also does not account for existing models in private contracting arrangements between insurers and providers to develop incentives or quality programs within their business relationship. This bill would be disruptive to furthering insurer/provider collaboration on new healthcare payment models. The bill did not advance.

**Legal**

**HB2233/PA 01-0184** (Rep. André Thapedi/Sen. John Mulroe) – Special Interrogatories  
**Effective August 2, 2019**  
This legislation was negotiated by the Illinois State Medical Society (ISMS) and the Illinois Trial Lawyers Association (ITLA). It will change the use of special interrogatories in Illinois. Currently, if either party requests a special interrogatory, it must be submitted to the jury. Under this legislation, all requests for special interrogatories will be discretionary with the judge. Additionally, currently, when an answer to a special interrogatory is inconsistent with the general verdict, the answer trumps the general verdict and the court may enter a judgment accordingly. Under the legislation if an answer to a special interrogatory is inconsistent with the general verdict, the judge will instruct the jury to give it additional consideration – and may ultimately order a new trial. However, the judge is not permitted to enter a judgment based on the answer to a special interrogatory that is inconsistent with the general verdict.

**Effective August 23, 2019**
This legislation extends the Out-of-State Person Subject to Involuntary Admission on an Inpatient Basis Mental Health Treatment Act from 2020 to 2025. The pilot created by this Act eases capability to transfer patients involuntarily committed for inpatient psychiatric treatment from one hospital to another that may be more convenient for a patient based on distance, but technically across state lines. Involuntary commitment requires court intervention, and this pilot allows health systems to more effectively navigate cross-state legal issues.

**HB2472/PA101-0025** (Rep. Kelly Burke/Sen. Terry Link) – Consumer Fraud and Deceptive Business Practices Act  
**Effective immediately**  
This new law amends the Consumer Fraud and Deceptive Business Practices Act (815 ILCS 505/1 et. seq.) by adding “personal injury” and “product liability” causes of action to the scope of the law. Although the Illinois Trial Lawyers Association (ITLA) agreed that the legislation was not intended to apply to services provided by a healthcare professional or provider, ITLA rejected our clarifying amendment. In collaboration with the Illinois State Medical Society (ISMS), IHA was able to include within the legislative intent language that the manufacture, distribution, or sale of a product or service that causes or contributes to cause bodily injury, death, or property damage should not be interpreted to apply to the provision of healthcare services by physicians, hospitals, hospital affiliates, or any other healthcare professional.

**HB3077** (Rep. Emanuel Chris Welch) – Copy of Medical Records for Free  
**Re-referred to Rules Committee**  
This bill would have amended the Inspection of Records provision of the Code of Civil Procedure by expanding the definitions of "health care facility" and "health care practitioner" to include entities that contract to provide copies of protected health information. Of particular note to hospitals, it would have removed the $20 handling charge for processing a request for a paper copy of healthcare records and provide one copy, without charge, of a patient's healthcare records, for the purpose of applying for disability or medical assistance benefits.

**HB3484** (Rep. Robyn Gabel) – Informed Consent  
**Re-referred to Rules Committee**  
This legislation would have amended the Medical Patients Right Act to require specific informed consent prior to the performance of biochemical testing for controlled substances. The informed consent would have required healthcare providers to provide patients with a written description of the foreseeable health and legal risks and benefits of the testing as well as reasonable alternatives. IHA strongly opposed this legislation as outside the scope of a healthcare provider’s role likely putting the provider and the hospital in legal jeopardy. While a final vote was not taken on this legislation, amendatory language was filed by the sponsor that would have not only achieved the intended goal for informed consent, but in a way amenable to IHA.

**Maternal Health**  
*NOTE: Beyond these brief summaries below, IHA will be sending memos to members with further details on various maternal health bills that become law.*
Effective July 12, 2019
This legislation creates the Task Force on Infant and Maternal Mortality Among African Americans Act. The Task Force, under the purview of the Illinois Department of Public Health (IDPH), is charged with establishing best practices to decrease infant and maternal mortality among African Americans in Illinois. The Task Force will be compromised of various healthcare professionals and associations representing healthcare professionals, as well as a hospital administrator. The Task Force will meet quarterly to review data and research to better understand the causes of high infant and maternal mortality among this population and produce an annual report to the General Assembly detailing its findings and any recommendations.

Effective Jan. 1, 2020
This legislation amends the Medical Patient Rights Act by setting certain rights women have with regard to pregnancy and childbirth. The 19 rights outlined include appropriate access to care prior to, during and after the pregnancy, choice in the type of maternity care provider and the setting in which a woman receives her care. Through IHA’s advocacy efforts the intent to support a pregnant mother’s ability to make choices through her pregnancy and delivery were maintained, with amendatory language added to ensure healthcare providers were not inadvertently required by law to provide care inconsistent with generally accepted medical standards.

HB3/PA101-0446 (Rep. Mary Flowers) - Hospital Report Card Act
Effective August 23, 2019
This legislation, as initially introduced, requires that each hospital include in its quarterly report instances of preterm infants, infant mortality, and maternal mortality and the reporting of racial and ethnic information of the infants’ mothers, along with the disparity of occurrences across different racial and ethnic groups. The goal of this legislation is to focus on maternal and infant mortality rates in disparate communities. Through IHA’s advocacy efforts we worked with the sponsor and the Illinois Department of Public Health (IDPH) to amend the bill so hospitals would not be required to determine the disparity of occurrences across different racial and ethnic groups because hospitals only have access to their own data and already report much of this data.

Effective August 23, 2019
This legislation requires the Illinois Department of Public Health (IDPH) to establish levels of maternal care for hospitals in Illinois. These levels of care are to be complementary but distinct from the perinatal levels of care system. The Department, by rule, will develop criteria for the designation of hospitals based on their capabilities. The Department will also collect additional data on maternal mortality and morbidity that could lead to further changes to the maternal levels of care. As with the perinatal levels of care, IHA will work closely with IDPH to advocate for appropriate criteria to be developed taking into account geographic and other regional
needs. IHA will also be engaged with the membership to gain feedback on the implementation of these proposals.

Effective January, 1, 2020
This legislation requires hospitals to have proper instruments available for taking a pregnant woman’s blood pressure.

Effective August 16, 2019
This legislation requires insurance coverage to include coverage for mental health conditions that occur during pregnancy or during the postpartum period.

Effective Jan. 1, 2020
This legislation requires all birthing facilities, including hospitals with at least one obstetric or neonatal intensive care bed, to conduct annual continuing education for providers and staff of obstetric medicine and emergency departments in the care of pregnant or postpartum women. This education must include management of severe maternal hypertension and obstetric hemorrhage. In addition, the legislation requires the Illinois Department of Public Health (IDPH) to collaborate with the Illinois Perinatal Quality Collaborative (ILPQC) to improve birth equity and reduce peripartum racial and ethnic disparities. IDPH’s Maternal Mortality Review Committee is to make available to all birthing facilities best practices for timely identification of all pregnant and postpartum women in the emergency department for appropriate and timely consultation with an obstetric provider. Due to IHA’s advocacy, requirements for hospitals to engage in unproven implicit bias training as well as develop individual protocols for identifying pregnant and postpartum women in the emergency department were removed.

Effective Jan. 1, 2020
This legislation creates the Maternal Mental Health Conditions Education, Early Diagnosis, and Treatment Act. It also requires the Department of Human Services (DHS) to develop educational materials on maternal mental health conditions and make them available to birthing hospitals who must distribute to employees regularly working with pregnant or postpartum women. Hospitals are to supplement these materials with information and resources relevant to their facility or region. IHA opposed the proposal as introduced, however, we negotiated language with the House and Senate sponsors that removed several vague definitions, limited requirements to birthing hospitals, and required DHS, instead of each hospital, to develop the materials for distribution.

**SB1909** (Sen. Cristina Castro/Rep. LaToya Greenwood) – Maternal Levels of Care
Held in House
This legislation would have authorized the Illinois Department of Public Health (IDPH) to develop maternal levels of care at birthing facilities that would align with the recommendations
of the American College of Obstetrics and Gynecology (ACOG). These would be complementary but separate from the current perinatal levels of care currently in place. In addition, the legislation would have increased insurance coverage for certain types of prenatal and postpartum care and expanded certain coverage under Medicaid. The legislation would have also required mandatory protocols and simulations for obstetric hemorrhage. IHA supported this legislation as a comprehensive approach to address high levels of maternal morbidity and mortality in Illinois and nationwide. This legislation did not receive a final vote in the House prior to adjournment.

**Patient Care**

**HB3038/PA101-0073** (Sen. Julie Morrison/Rep. Michael Unes) – Sexual Assault Treatment Effective July 12, 2019
The legislation amends the Sexual Assault Survivors Emergency Treatment Act (SASETA) to allow treatment hospitals with approved pediatric transfer to accept transfers of adults from full transfer hospitals until January 1, 2022. The treatment hospital with approved pediatric transfer must be geographically closer to the transfer hospital than a treatment hospital or another treatment hospital with pediatric transfer and such transfer is not unduly burdensome to the survivor. IHA supported the bill.

Creates the Reproductive Health Act and establishes an individual’s fundamental right to make individual decisions about reproductive healthcare including contraception, abortion, and maternity care. It repeals certain abortion restrictions and penalties, mandates private health insurance coverage of abortions, and eliminates outdated language. Other key provisions and actions include:

- Healthcare professionals defined as a physician, physician assistant (PA) or advanced practice nurse (APN), shall make a report to the Illinois Department of Public Health (IDPH) of each abortion performed.
- Both the Nurse Practice Act and Physician Assistant Practice Act were amended to clarify that the scope of practice for an APN or PA does not include operative surgery, but may assist at surgery.
- The Act repeals the provision requiring a physician to be on the board of an Ambulatory Surgical Treatment Center (ASTC) devoted primarily to providing abortions and revises the definition of an ASTC to not include abortion facilities that only utilize certain anesthesia procedures.
- The Act repeals the section in the Sexual Assault Survivors Emergency Treatment Act that stated nothing in the Act required a hospital or pediatric healthcare facility to provide any services related to abortion.
- Through IHA’s advocacy efforts with the Illinois State Medical Society, the Health Care Right of Conscience Act definition of healthcare was expanded to include abortions as the term is used throughout the Reproductive Health Act and means a hospital or healthcare professional retains the right to not participate in providing this service without fear of discrimination or liability.
HB3662 (Rep. Mary Flowers) – Diagnostic Algorithm  
Re-referred to Rules Committee  
This legislation would have required the Illinois Department of Public Health (IDPH) and the Department of Innovation and Technology (DoIT) to certify any diagnostic algorithm for diagnosing a patient prior to its use. The legislation would have further required hospitals to notify patients of the use of diagnostic algorithms and be given the option to be treated without the use of algorithms. Algorithms are important tools that healthcare providers use to assist in healing patients but do not replace medical judgment. IHA successfully opposed this legislation as beyond the scope of IDPH and DoIT as well as significantly hindering patient care. The legislation was not called for a vote.

Patient Safety/Security

HB161 (Rep. Mary Flowers) – Designation of Patient Care Areas  
Re-referred to Rules Committee  
The legislation would have amended the Hospital Licensing Act, the Code of Criminal Procedures of 1963 and the Unified Code of Corrections to require hospitals to designate “patient-care areas” where a peace officer may not enter without seeking permission from the hospital health supervisor or having a warrant. IHA opposed this legislation as not only unfeasible but also a risk to good patient care and the safety of all patients in the hospital. Hospitals work closely with law enforcement; restricting law enforcement access as proposed would not be good policy. This legislation did not advance.

HB191 & SB1410 (Rep. LaShawn Ford/Sen. Laura Murphy) – Metal Detectors  
Referred to Rules Committee and Assignments Committee  
These pieces of legislation would have required hospitals to have metal detectors at each point of entry. Those entering a hospital via ambulance would be exempt from screening. IHA opposed this legislation, advocating that mandatory metal detectors would actually put patients at risk who might suffer undue injury or harm while waiting in line for screening. High costs and operational challenges to implement such legislation were also reasons for opposition. After months of discussion, these bills were not called for a vote in committee.

Re-referred to Rules Committee  
This legislation would have created a 1% tax on firearm ammunition that would be allocated to schools to support a newly-created trauma response protocol. School boards were to develop this trauma response protocol in response to a traumatic event at a school including, but not limited to, a shooting at the school. The closest hospital would be mandated to establish an agreement with a school district to provide “mental health first responders” and "immediate grief and trauma-based counseling" for a trauma response protocol, with the implementation mandate taking effect on the enactment date of the law. IHA will work with the sponsor in the coming year to address concerns related to hospital-based operational response and workforce requirements.

HB3506 (Rep. Celina Villanueva) – Patient Financial Status
**Re-referred to Rules Committee**
This bill would have amended the Hospital Licensing Act and the University of Illinois Hospital Act to prohibit a hospital from inquiring about a patient’s financial status and to treat the patient in a different manner based solely on his or her financial status. IHA provided the sponsor with information on the importance of financial conversations to assist the patient in obtaining health coverage and financial assistance as well as current Illinois law pertaining to free and discounted care. The sponsor did not advance the bill.

**SB1145 (Sen. Julie Morrison) – Guns – Mental Health Reporting & Fines**
Re-referred Assignments Committee
This bill would have allowed the Illinois Department of Public Health (IDPH) to impose fines or sanctions on hospitals and other healthcare facilities that fail to comply with reporting requirements related to determining whether a person is disqualified from gun ownership. IHA worked with the sponsor, IDPH, the Illinois Department of Human Services (IDHS) and State Police to prioritize improving user access to the IDHS Firearm Owner's Identification (FOID) Mental Health Reporting System and IDHS creating a list of mandated reporting facilities and healthcare professionals.

Passed House But Held in Senate
House Amendment 1, held in the Senate Judiciary Committee, would have expanded the definition of "clear and present danger," as the criteria qualified healthcare professionals within a hospital are currently mandated to use to determine if a patient should be reported to the Illinois Department of Human Services (IDHS) Firearm Owner's Identification (FOID) Mental Health Reporting System within 24 hours of their professional determination. Specifically, when a patient demonstrates threatening physical or verbal behavior, “any act that is intended to cause or create a risk and does cause or create a risk of death or great bodily harm to one or more persons” would also qualify for reporting. This change would have marked the fourth time this statute altered healthcare professional reporting requirements since 2013. No healthcare professional education or implementation period to ensure accurate reporting was included in the proposed legislation prior to the immediate effective date.

**Personal Information/Privacy**

Effective Jan. 1, 2020
This legislation amends the Personal Information Protection Act (815 ILCs 530/10) (“PIPA”) to require data collectors to report breaches of more than 100 Illinois residents’ information as the result of a single breach to the Attorney General. It would also require the Attorney General to report to the General Assembly information concerning data breaches yearly. There is an exception for HIPAA covered entities that states that the reporting requirements do not apply to covered entities so long as they are in compliance with HIPAA. Thus, this legislation should not impact hospitals. (Additionally, PIPA also already contains a provision
(Section 50) that covered entities in compliance with HIPAA are deemed to be in compliance with PIPA.)

This legislation is similar to HB3200 (which did not pass) that also proposed to amend PIPA by requiring, among other things, notification to the Attorney General of breaches. The differences between this bill and HB 3200 were that: (i) HB 3200 would have required notice to the Attorney General for each breach, while SB 1624 only requires notice if a single breach affects 100 or more Illinois residents; (ii) HB 3200 would have required notice to the Attorney General within 5 days of the breach, while SB 1624 requires notice within 14 business days or when notice is provided to consumers (whichever is sooner); and (iii) HB 3200 would not have required the Attorney General to make an annual report to the General Assembly on the number of breaches, while SB 1624 does.

This legislation is also similar to HB2784 (which did not pass) that also proposed to amend PIPA by expanding the categories and types of information protected. Specifically, HB 2784 would have: (i) created a new category of protected information called “consumer marketing information” (i.e., information related to a consumer’s online browsing history, search history, purchasing history, etc.); (ii) created a new category of protected information called “geolocation information” (i.e., information derived from use of an electronic device, sufficient to identify the person’s location, and determine an individual’s regular pattern of behavior); (iii) amended the definition of “medical information” to include genetic information; and (iv) amended the definition of “personal information” to state that it means the individual’s first name or initial and last name or email address (previously it was first name or initial and last name) in combination with other information (and such other information was amended to include the new categories of geolocation information, consumer marketing information and audio recordings).

HB3130 (Rep. Allen Skillicorn) – Genetic Information Privacy Act

Re-referred to Rules Committee

This bill would have expanded who is covered by the existing Genetic Information Privacy Act (410 ILCS 513/10) to specifically include direct-to-consumer genetic testing (e.g., 23 and Me, etc.) within the definition of “genetic testing” under the Act. Thus, all of these companies would have needed to comply with the existing law – which requires specific consent of the person tested to share the results beyond that person or his/her representative. This bill was similar to, but less expansive than SB1307 (which also did not pass). SB 1307 would have revised the existing law to prevent a covered entity, without obtaining patient consent, from using and disclosing genetic information for each of the following activities: (i) treatment, payment and health care operations; (ii) health oversight activities; (iii) public health activities; (iv) to business associates; (v) to an HIE; and (v) of limited data sets and de-identified information. IHA successfully defeated SB 1307 in order to ensure that hospitals can continue these activities as currently permitted by HIPAA.

Regulatory

Effective January 1, 2020
This legislation sets new requirements under the Equitable Restrooms Act to require existing or future single-occupancy restrooms within a place of public accommodation (including hospitals) or public building to be identified as all-gender and designated for use by no more than one person at a time or for family or assisted use. These restrooms are to be outfitted with exterior signage that marks it as a restroom but prohibits verbiage limiting use to any specific gender.

Effective July 15, 2019
This legislation amends the Health Facilities Planning Act making certain changes to the Certificate of Need (CON) and Certificate of Exemption (COE) process. Key provisions include: (1) requiring a CON, instead of a COE, to close a facility; (2) limiting the use of the COE process to discontinue a service to once every six months; and (3) allowing the Review Board to defer acting on an application to close a facility for six months if litigation that names the Board as a party or alleges fraud is pending. Importantly, the legislation does not change the more streamlined COE process for changes of ownership and does not authorize the Governor to override Review Board decisions, as originally proposed. This compromise legislation, worked out by IHA, Health Facilities and Services Review Board staff and legislative sponsors, makes significant improvements to the originally introduced legislation that would have undone many streamlining provisions that IHA had successfully advocated for in 2015.

Effective June 21, 2019
This legislation sets new emission standards for plants that emit ethylene oxide (EtO), a major sterilant of medical supplies. The legislation exempts hospitals that use ethylene oxide for in-house sterilization from these new standards. IHA has been an active stakeholder in the discussions around enhanced regulation of EtO since the fall of 2018. Thanks to frequent member input, IHA has been able to provide the Governor’s Office and key legislators the information necessary to allow for appropriate regulation to better protect the public’s health while ensuring continued access to safe and sterile medical supplies.

**Workers’ Compensation**

**HB2301/PA101-0384** (Rep. Debbie Meyers-Martin) – Labor-Employee Class (Workers’ Compensation)
Effective Jan. 1, 2020
This legislation changes the criteria for who may represent the employee class on the Illinois Workers’ Compensation Commission, the Workers’ Compensation Advisory Board, and the Workers’ Compensation Medical Fee Advisory Board. The Workers’ Compensation Act currently requires a certain number of members to be selected from the class of employees covered under the Act. Under this legislation, an employee class representative must instead be from a labor organization recognized under the National Labor Relations Act or an attorney who has represented labor organizations or employees in workers’ compensation cases.
**Workforce: Training, Scope and Mandated Reporting**


**Effective January 1, 2020**

The bill requires the Department of Family and Children Services (DCFS) to notify the Directors of the Departments of Healthcare and Family Services (DHFS) and Public Health (DPH) when any report of suspected child abuse or neglect in a hospital has been called in to the statewide DCFS hotline. Whenever a report alleges that a child was abused or neglected while receiving care in a hospital, DCFS must send final findings to the Directors of DHFS and DPH. DPH will receive information from reports of unfounded abuse or neglect in a hospital in order to conduct its licensing investigation. The bill removes the necessity of seeking access or release of these records by the Director of DCFS or their designee. [ANCRA is Abused and Neglected Child Reporting Act]


**Effective July 22, 2019**

This legislation expands healthcare professional eligibility under state programs that financially incentivize full-time practice in Designated Shortage Areas, dependent on annual state funding. Grants for residency programs, medical student scholarships and loan repayment assistance formerly limited to primary care physicians will expand eligibility to general surgeons, emergency medicine physicians and obstetricians. Primary care physicians applicable for the incentives were clarified to include general internists, family physicians and general pediatricians.

**SB1135/PA101-0084 (Sen. Don Harmon/Rep. Sara Feigenholtz) – Prescribing Psychologists**

**Effective July 19, 2019**

This legislation expands the facilities at which a psychologist applying for a prescribing psychologist license may complete their full-time practicum of supervised clinical training, to include undefined medical centers, patient-centered medical homes or family-centered medical homes, women’s medical health centers, Federally Qualified Health Centers and healthcare facilities located at federal and state prisons. Hospitals, hospital outpatient clinics and community mental health centers were already approved training facilities. The 14-month supervised clinical training is aligned with physician, physician assistant or advanced practice nurse education as defined by specific accreditation bodies. Regarding prescriptive authority, all prescriptions written by a prescribing psychologist must contain their name and signature, rather than a collaborating physician. Prescribing psychologists licensed in Illinois are added to a group of healthcare professionals who may engage in the practice of telehealth in Illinois to the extent of their scope of practice established in their respective licensing Acts.


**Effective Jan. 1, 2020**

This legislation sets certain training requirements for phlebotomists to draw blood from children and adults with intellectual and developmental disabilities. It requires the Illinois Department of Public Health (IDPH) to make available training materials on the most current
methods of drawing blood from these patient populations. It also requires that these materials be used in any initial employment training of phlebotomists as well as any ongoing training to maintain competencies and certifications as a phlebotomist. Through IHA’s advocacy efforts, this legislation was significantly amended from its introduced version which would have placed onerous requirements on hospitals to develop their own training resources as well as maintain certain blood drawing equipment that are no longer the standard of care. Further details will be provided in a member memo should this legislation become law.

Effective Jan. 1, 2020
This legislation requires any report of alleged abuse and neglect of a child by anyone other than a parent, immediate family member, person responsible for the child’s welfare, individual living with the child, or paramour of the child’s parent that is received by the Department of Children and Family Services (DCFS) to be immediately referred to the appropriate law enforcement agency for consideration for a criminal investigation. This requirement would include allegations made in a hospital setting.

Effective Jan. 1, 2020
This legislation allows licensed advanced practice registered nurses (APRNs) with specific psychiatric mental health certifications to order patient restraint or seclusion, as well as execute a certificate that a patient is subject to involuntary admission based on their examination within a hospital. Personal examinations following an emergency admission for use with certificates for involuntary admission can now be carried out via telehealth in real time (i.e., a synchronous examination), when a psychiatrist is not on-site within the time period required for the examination. If a patient examination for these purposes is performed via telehealth, it must be noted on the certificate.

**SB1715/PA101-0349** (Sen. Michael Hastings/Rep. Sara Feigenholtz) **– Pharmacy Practice - Injections**
Effective Jan. 1, 2020
This legislation allows pharmacists to inject long-term antipsychotic medications with a valid physician prescription, following completion of appropriate training set by state rule or hospital pharmacy and therapeutics committee policies and procedures. The pharmacist must provide notification to the patient's physician and keep appropriate records. Following a physician’s initial administration of an opioid antagonist, the bill also allows pharmacists to inject long-acting or extended release form opioid antagonists to treat substance use disorder. The pharmacist must have a valid physician prescription, along with either appropriate training set by state rule or following hospital pharmacy and therapeutics committee policies and procedures.

Effective Jan. 1, 2020
This legislation is a broad reform of the Abused and Neglected Child Reporting Act (ANCRA), re-organizing and expanding who is mandated to report across broad professions and requiring
IHA worked with the sponsor to remove hospitals, as the only facility listed, from a list of medical personnel required to report. Instead, the legislation focuses reporting requirements on medical administrators or personnel engaged in the examination, care, and treatment of persons, among an extensive group of specific medical and mental healthcare personnel. Training provided by the Department of Children and Family Services (DCFS) or an authorized entity must be completed within three months of medical personnel’s date of engagement in a professional or official capacity, if they work with children. This training must be completed every six years by medical personnel who work with children. If medical personnel do not work with children, they must attest that they understand they are a mandated reporter with specific responsibilities required of reporters at each licensure renewal. When two or more persons who work within the same workplace and are required to report, one reporter may now be designated to make a single report, for which the process is described. DCFS must provide a free, web-based training for reporters.

**HB10 & HB197 (Rep. Mary Flowers) – Pharmacy-Prescription Limits**
Re-referred to Rules Committee

These bills aimed to amend the Pharmacy Practice Act to require: at least one registered pharmacy technician be on duty whenever the practice of pharmacy is conducted; pharmacies fill no more than 10 prescriptions per hour; 10 pharmacy technician hours per 100 prescriptions filled; a complete and accurate record of pharmacist break periods; and a pharmacist cannot work more than 8 hours a work day. A similar bill was introduced in 2017 that resulted in the development of the Collaborative Pharmaceutical Task Force to discuss and make recommendations on how to further advance the practice of pharmacy in a manner that recognizes the needs of the healthcare system, patients, pharmacies, pharmacists, and pharmacy technicians. IHA participates as a member of the task force which is nearing the end of its charge and currently preparing recommendations for legislation that will enhance safety.

**HB1459/SB152 (Rep. Sara Feigenholtz/Sen. Iris Y. Martinez) – Nurse Licensure Compact**
Re-referred to Rules Committee/Re-referred to Assignments Committee

These bills would allow nurses to practice in their home state as well as other states that have passed the Nurse Licensure Compact. The goal of this legislation is to expand mobility of nurses to allow advanced technology as part of our healthcare system, decrease the duplicative licensure system for nurses practicing in multiple states, and to promote uniformity of licensing requirements, public safety and public health. To date, nearly 30 other states have passed this act, an initiative that models the portability of state driver’s licenses. IHA and other stakeholder groups have supported this initiative for many years. Due to strong union opposition, it has not advanced.

**HB2565 (Rep. Anne Stava-Murray) – Prohibit Restrictive Covenants**
Lost in House

This bill would have amended the Illinois Freedom to Work Act (820 ILCS 90/1 et. seq.) by expanding the law to apply to all employees (rather than only low-wage employees). Of particular impact on hospitals, it would also have prohibited all covenants not to compete. This bill was similar to HB2328 that would have amended the Hospital Licensing Act to state that employment agreements between hospitals and physicians could not contain any covenants not to compete. Neither bill advanced.
**HB2604** (Rep. Fred Crespo), **HB3585** (Rep. Theresa Mah), **SB1908** (Sen. Cristina Castro)

**Mandatory Nurse Staffing Ratios**

Re-referred to Rules and Assignments Committees

Each of these bills would have imposed nurse staffing ratios on hospitals, ASTCs and long-term acute care hospitals. IHA strongly opposed nurse staffing ratios and successfully argued that a one-size-fits-all approach to nurse staffing levels overrides the expertise and judgment of local hospital nurse professionals and would not improve patient outcomes. None of these bills were called for votes. More information will be forthcoming this summer. Click [here](https://example.com) (password required) to access IHA advocacy materials.

**HB2638** (Rep. Marcus Evans) – **Opioid Prescriber Requirements**

Re-referred to Rules Committee

This bill would have required prescribers to offer a prescription of naloxone or another drug approved by the U.S. Food and Drug Administration for the complete or partial reversal of opioid depression to patients who meet certain conditions. The bill would have required prescribers to provide education to these patients on overdose prevention and the use of naloxone and linked non-compliance to administration sanctions under a provider’s licensing board. The bill would have exempted prescribers to an inmate or youth under jurisdiction of the Departments of Corrections or Juvenile Justice. House Amendment 1 to the bill removed a provision from the bill as introduced stating that non-compliance with prescriber requirements does not create a private right-of-action against a prescriber, or limit prescriber liability to negligent failure to diagnose or treat a patient.

**HB3361** (Rep. Fred Crespo) – **RN Reporting Time Pay**

Referred to Assignments Committee

This legislation would amend the minimum wage law to require nurses to be paid a minimum of 4 hours at the regular rate of pay when required to report to work but then not needed or provided less than one-half of the scheduled day's work. Hospitals work to balance the changing patient needs and patient census with available staff and finite resources. Paying staff when not working diverts finite resources away from incentive pay offered when additional staff are needed due to high census and patient care needs. After multiple amendments to this legislation, it did not advance out of committee. We expect this issue to return.

**HB3840** (Rep. LaShawn Ford/Sen. Mattie Hunter) – **Hospital Opioid Antagonist**

Referred to Assignments Committee

This bill, introduced near the very end of session, sought to require hospitals to send an opioid overdose survivor home from the hospital with either one dose of an opioid antagonist (e.g., naloxone) or a prescription – at no charge. As drafted, the bill was not operationally, clinically or fiscally sound. The bill directs “hospitals” to write prescriptions; however, hospitals are not prescribers. For fentanyl, one dose of an opioid antagonist alone won’t typically address an overdose. At approximately $150 per dose, most survivors wouldn’t be able to pay for the antagonist and, as drafted the legislation would prohibit hospitals from accessing Medicaid or private insurance for any reimbursement. Lastly, there is nothing in the bill to prohibit drug manufacturers from raising the price to capitalize on this new mandate. IHA is working with interested parties over the summer to address these concerns.