Illinois Health and Hospital Association

September 14, 2021

IHA Overview of General Assembly's Spring 2021 Session

The following is a detailed overview of the key bills and issues that IHA worked on during the General Assembly's Spring 2021 session to ensure the best possible outcomes for the hospital community.

State Budget & Finance

SB2800 (Sen. Don Harmon/ Rep. Emanuel Chris Welch)
State Budget - FY2022
Public Act 102-0017
The budget totals approximately $42 billion and does not have any cuts to the Medicaid budget, including the Hospital Relief Fund. The budget assumed funding for the following items through the Healthcare Provider Relief Fund:

- Eliminating SMART Act rate reduction;
- Funding a floor per diem rate of at least $630 per day for inpatient psychiatric services for all Safety Net Hospitals;
- Funding a pool of $50 million, to be disbursed among Safety Net Hospitals that maintain perinatal designation from the Illinois Department ofhb Public Health (IDPH);
- Funding $10 million to Critical Access Hospitals to preserve or enhance perinatal and OB/GYN services, behavioral healthcare including substance use disorders (SUDs), other specialty services, as well as the expansion of telehealth services by the receiving hospital;
- Allowing for medical coverage for non-citizens aged 55-64 years who would otherwise be eligible for the medical assistance program except for their citizenship status;
- Funding for year two of Healthcare Transformation;
- Reauthorization of hospital transformation capital;
- $30 million in funding to Safety Net Hospitals and $150 million in funding to hospitals, excluding Safety Net Hospitals, through the American Rescue Plan Act (ARPA), as well as $58.5 million for specified hospitals through ARPA; and
- $31.5 million in funding to Safety Net Hospitals through general revenue funding.

SB2017 (Sen. Don Harmon/ Rep. Greg Harris)
Budget Implementation - Key Healthcare Related Provisions
Public Act 102-0016
The budget implementation bill, also referred to as the BIMP, includes spending authority for items funded in the appropriations bill. There are many other initiatives in the BIMP that are not healthcare specific related issues. These are not included in this summary, but could impact the hospital community on an individual organizational level.

SMART Act Rate Reduction Reversal: Effective July 1, 2021, eliminates the SMART Act rate reduction of 3.5% to hospitals, which has been in place since 2012.

Critical Access Hospital Support Funds: Subject to appropriation, provides $10 million to Critical Access Hospitals to preserve or enhance perinatal and OB/GYN services, behavioral healthcare including SUDs, other specialty services, as well as the explanation of telehealth services by the receiving hospital. Distribution of funding will be established by rule. This is an annual pool that shall be distributed only if funding is included in Department of Healthcare and Family Services' (HFS) budget each year. FY22 funding for this new initiative is assumed by the Governor's Office of Management and Budget (GOMB) to be authorized within the HFS Healthcare Provider Relief Fund appropriations authority.

Hospital Closure Clawback: Effective upon becoming law, for FY22, a general acute care hospital that ceases to provide hospital services before July 1, 2022, and within 12 months of a change in the hospital's ownership status that was approved by the Health Facilities and Services Review Board between March 1, 2021 and March 31, 2021 shall repay to HFS the fee-for-service supplemental payments and pass-through payments received in FY21.

Medical Services to Noncitizens Aged 55-64: By May 30, 2022, HFS may provide medical services to noncitizens aged 55-64 who would otherwise be eligible for the Medical Assistance Program if not for their non-citizenship. This is an extension of the medical services for immigrant seniors aged 65 and older that was implemented in December 2020. FY22 funding for this new initiative is assumed by GOMB to be authorized within the HFS Healthcare Provider Relief Fund appropriations authority.

Trauma Recovery Team-Based Model of Care: Creates the Reimagine Public Safety Act. Requires HFS to design, receive approval from federal Centers for Medicare & Medicaid Services, and implement, by January 15, 2022, a team-based model of care system to address trauma recovery from chronic exposure to firearm violence for Illinois adults and children under the age of 19 and reimburse for outreach services, case management, community support services, and group and individual therapy.

SB2294 (Sen. Ann Gillespie/Rep. Greg Harris)
Medicaid Omnibus
Public Act 102-0043
The Medicaid Omnibus is a package of legislative initiatives spearheaded by the bipartisan/bicameral Legislative Medicaid Working Group. Many of the initiatives in this Omnibus originated as standalone legislation that was negotiated into the larger package. In total, this legislation includes 19 separate initiatives that impact the Medicaid program.

Hospital Opioid Inpatient Status: Effective upon becoming law, this ensures medical assistance to patients experiencing an opioid-related overdose or withdrawal can be admitted on an inpatient status when medically necessary and HFS or MCOs must reimburse for these services. Currently, some MCOs frequently require patients to remain in observation status for a specified amount of time before a hospital may admit them on an inpatient status. It also reverses a requirement of the SMART Act by ending, on July 1, 2021, the service limit on hospital admissions for detoxification within 60 days. The initiative was originally introduced by Rep. Camille Lilly (HB2899) and Sen. Kimberly Lightford (SB2337). The final language in SB2294 was negotiated by IHA, HFS, Illinois Association of Medicaid Health Plans, and the Association of Safety-Net Hospitals.

Long-Acting Injectables Hospital Reimbursement: Effective January 1, 2022, this requires the medical assistance program to separately reimburse long-acting injectable medication for mental health or substance use disorder treatment in the hospital inpatient setting. This initiative was originally introduced by Sen. Michael Hastings (SB254). The final language in SB2294 was heavily negotiated by

IHA with Alkermes, a pharmaceutical manufacturing company, and HFS to ensure proper reimbursement beyond the customary all-inclusive inpatient rate for the cost of these emerging drug therapies.

CHIP/All Kids Transfer to Medicaid Expansion: Effective upon federal approval and HFS transferring youth to Medicaid Title XIX program, this makes the State Children's Health Insurance Program Act (SCHIP) and the Covering All Kids Act inoperative if HFS receives federal approval to expand the medical assistance program to cover children at or below 313% of the Federal Poverty Level and transitions the previous SCHIP covered children to the Medicaid Title XIX program. Provides emergency rule making authority to HFS to implement approved changes and makes other technical adjustments to the program related to individuals previously covered by the SCHIP and All Kids programs including the option for HFS to forgive outstanding unpaid premium debts. This language was originally filed by Rep. Robyn Gabel (HB3119) and was condensed in SB2294.

Medical Assistance Program COVID-19 Public Health Emergency Eligibility: Effective upon becoming law, provides that individuals deemed eligible under the medical assistance program during the COVID-19 Public Health Emergency (PHE) shall remain eligible for a period up to 12 months after the PHE expires and provides for the implementation of procedures to provide enrollment assistance agents for the medical assistance program. This language was originally filed by Rep. Robyn Gabel (HB3119).

Healthy Kids Immunization Reimbursement: Beginning January 1, 2022, requires the medical assistance program to reimburse hospitals and other providers for immunizations under the Healthy Kids Program at no less than 70% of the median regional maximum administration fee established by the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services. This language was originally filed by Rep. Robyn Gabel (HB347) and was negotiated between HFS and Illinois Chapter, American Academy of Pediatrics.

Pilot Program Lock-outs: Effective upon becoming law, establishes a pilot program to act as a residential research hub with the goal of avoiding lock-out situations pursuant to the goals of the Custody Relinquishment Prevention Act. The pilot program, under the Community and Residential Services Authority, has the duty to research and identify appropriate residential settings for youth in an emergency room beyond 72 hours or beyond medical necessity in a psychiatric hospital. It does not include a rate change for beyond medical necessity.

HFS MCO Claims Reporting: Effective upon becoming law, eliminates the requirement for HFS to post a contracted claims report for MCO payments to hospital providers on its website every three months, as required by HealthChoice Illinois. HFS must still post a hospital MCO claims processing and performance analysis to its website every six months. HFS has not posted a report on its website since the second quarter of 2019. This language was originally filed by Rep. Bob Morgan (HB 3069).

This legislation also changes the following:

- Requires HFS to establish a program for the implementation of Certified Community Behavioral Health Clinics;
- Requires the medical assistance program to cover services rendered by persons licensed under the Professional Counselor and Clinical Professional Counselor Licensing and Practice (PCCPC) Act, and the Marriage and Family Therapy (MFT) Licensing Act;
- Expands Medicaid coverage of services (i.e., peer services) rendered by certified veteran support specialists;

- Requires the medical assistance program to cover chiropractic services;
- Requires the medical assistance program to cover individual and group tobacco cessation counseling and telephone-based counseling services and tobacco cessation medications provided through the Illinois Tobacco Quitline;
- Requires the medical assistance program to cover immunosuppressive drugs and related services associated with post-kidney transplant management for noncitizens who are ineligible for comprehensive medical benefits;
- Requires HFS to implement the Senior PACE Program;
- Requires HFS to pay a supplemental $26 per diem rate to all supportive living facilities (SLF) with the additional 10% FMAP from April 1, 2021 through March 31, 2022;
- Extends the sunset date of the Illinois Health Information Exchange and Technology Act to January 1, 2027;
- Raises the cost limit for wheelchair repairs before prior approval is needed from $400 to $750;
- Requires HFS and the Department of Human Services (DHS) to apply for a waiver to provide a Bridge to Community Supports for Young Adults with Developmental Disabilities Waiver Program to serve young adults with developmental disabilities; and
- Increases dental rates under the medical assistance program by $10 million.

HB3493 (Rep. Delia Ramirez)
Medicaid Coverage Non-citizens
Re-referred to House Rules
This bill would have provided Medicaid coverage to non-citizens age 19-64 who would otherwise be eligible for Medicaid if not for their citizenship status. The income limits would have been at or below the federal poverty limit (FPL) plus 5% for applicable family size. While this legislation was never assigned to a committee in the House, Medicaid coverage to non-citizens age 55-64 was included in SB2017 (Budget Implementation).

SB688 (Sen. Laura Murphy)
Prompt Payment Interest Reduction
Re-referred to Senate Assignments
This legislation would have reduced the prompt payment interest rate from 1% each month after a 90 day period to the greater of either 0.25% each month or an annual rate of two times the percentage increase in the Consumer Price Index (CPI) for All Urban Consumers during the 12-month period preceding the start of that fiscal year. The CPI increased 1.7% over the last 12 months (as of March 2021), which would mean the annual prompt payment interest would only be 3.2%, rather than 12% annually. This reduction would have further incentivized the State to borrow funds from hospital providers by delaying payment to Illinois' hospitals and health systems. IHA and other state vendors opposed this legislation. It failed to advance out of the Senate.

Health Policy & Regulation

Behavioral Health/Substance Use Disorder

HJR1 (Rep. Maurice A. West, II/Sen. Steve Stadelman)
Teen Mental Health Support
Adopted Both Houses
This joint resolution urges Illinois schools to provide education for all students in grades six to 12 on how to identify, understand, and respond to signs of addictions and mental illnesses, as well as provide

instruction on how to help someone who is developing a mental health problem or experiencing a mental health crisis.

HR106 (Rep. Camille Y. Lilly)
Mental Health Issues
Resolution Adopted
This resolution urges the members of the General Assembly to have discussions and forums with their communities to promote awareness of mental health issues and access to mental health resources. Members of the General Assembly and all school districts are encouraged to post information on mental health issues and local treatment resources on their websites. School districts are encouraged to implement mental health screenings to properly identify students with mental health problems. The federal government is encouraged to improve mental health awareness, treatment, and funding to improve the lives of citizens struggling with mental health issues.

HB348 (Rep. Deb Conroy); SB2535 (Sen. Melinda Bush); SB2539 (Sen. Melinda Bush)
Controlled Substances – Prescribing
HB348 Re-referred to House Rules
HB2535 Re-referred to Senate Assignments
SB2539 Referred to Senate Assignments
These bills would have required prescribers to offer a prescription for naloxone or a similar drug when the prescription dosage for the patient is 50 or more morphine milligram equivalents of an opioid medication per day; an opioid medication is prescribed concurrently with a prescription for benzodiazepine; or the patient presents with an increased risk for overdose, including a patient with a known history of overdose, substance use disorder, or at risk for returning to a high dose of opioid medication to which they are no longer tolerant. Prescribers would have been required to provide educational information concerning overdose prevention and the use of naloxone or similar drugs to patients receiving a prescription and to one or more persons designated by the patient. A minor's parent or guardian would be given this information. Non-compliance would result in administrative sanctions. The provisions did not create a private right of action against a prescriber, nor did they limit a prescriber's liability for the negligent failure to diagnose or treat a patient.

HB2595 (Rep. Deb Conroy/Sen. Laura Fine); SB697 (Sen. Laura Fine)
Insurance – Mental Health
HB2595 Public Act 102-0579
SB697 Referred to Assignments Committee
This legislation creates the Generally Accepted Standards of Behavioral Health Care Act. Commercial insurers and Medicaid managed care organizations (MCOs) are required to cover medical necessary mental health and substance use disorder treatment consistent with generally accepted standards of care. No specific limit can be set on the duration of benefits or coverage for medically necessary treatment nor can coverage be limited to alleviating a patient's symptoms. Requires all denials and appeals to be reviewed by a professional with relevant experience. Requires commercial insurers to apply treatment criteria from unaffiliated nonprofit clinical societies for mental health disorder medical necessity determinations, while Medicaid MCOs must apply criteria determined by HFS that are consistent with generally accepted standards of care. Utilization review criteria must be consistent with generally accepted standards of care and be provided to providers and patients upon request, at no cost. Outlines penalties for illegal practices and requires analyses to ensure decision-making for utilization reviews are consistent. Prohibits commercial insurers from limiting or excluding coverage for medically necessary services because the services could or should be covered by a public entitlement

program like Medicaid or Medicare, unless benefits have already been authorized and provided by one of these programs.

HB2589 (Rep. Deb Conroy/Sen. Laura Fine)
Substance Use Disorder – Opioids
Public Act 102-0598
This legislation incorporates amendatory language supported by IHA to increase access to opioid use disorder treatment funding. Specifically, streamlining hospital requirements to participate in the Drug Overdose Prevention Program (DOPP). This will allow for easier access to grants to purchase and distribute opioid antagonists and fund related programs. For DOPP enrollment purposes, hospitals are now exempt from existing mandates to demonstrate proof of a standing order or attest to programmatic requirements. The legislation expands DOPP eligible grant activities, and requires the Department of Human Services (DHS) to consider the overall rate, rate of increase, and racial disparities in opioid overdoses experienced by communities served. Clarifies that an opioid antagonist may be obtained, stored, and dispensed in a hospital, its affiliate, or other facilities when a patient is provided with specified information. More broadly defines Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for persons at risk of substance use disorders, and now includes hospitals as a specified setting for treatment. Medicaid will be required to cover hospital fees (in addition to the existing mandate to cover pharmacy fees) related to opioid antagonist dispensing, distribution and administration. Effective January 1, 2022, HFS must develop and seek federal approval of an SBIRT benefit for qualified providers, including hospitals.

SB106 (Sen. Sara Feigenholtz/Rep. Delia C. Ramirez)
DCFS – Annual Reports for Youth in Care
Public Act 102-0076
This legislation expands upon current provisions requiring the Department of Children and Family Services (DCFS) to submit annual reports to the General Assembly concerning youth in care awaiting placement to include psychiatric hospitalization. Reports will be permanently required to be submitted no later than December 31 of each year, and posted on DCFS' website. The reports are required to include additional information, including (1) the number of youth placed in out-of-state residential treatment facilities, whether each youth was referred to any in-state programs for placement and, if so, the number of in-state referrals for each youth prior to referring the youth to out-of-state programs; (2) the number of youth not in the temporary custody or guardianship of DCFS who are the subjects of certain child protection and welfare cases, including but not limited to, those youth for whom DCFS is required to make medical assistance payments because they were hospitalized in inpatient psychiatric hospitals or units and were beyond medical necessity during DCFS' involvement with the case; and (3) the number of youth in emergency rooms for longer than 24 hours waiting for admission to a psychiatric hospital bed. Effective upon enactment.

SB586 (Sen. Julie A. Morrison)
MHDD CD-Mental Health Facility
Re-referred to Senate Assignments
In the case of In re Linda B., 2017 IL 119392, 91 N.E.3d 813 (Ill. 2017), the Illinois Supreme Court determined that all persons receiving inpatient mental health treatment are in a "mental health facility" under the definition provided by the Mental Health and Developmental Disabilities Code ("Code"). This decision eliminated any uncertainty that the Code applied to facilities not traditionally considered a "mental health facility" such as emergency departments, medical or surgical units of general hospitals, and nursing homes. This bill would have exempted facilities from the definition of "mental health

facility" and thus required compliance with the Code. The bill would have exempted facilities if the patient were admitted to the facility solely for obtaining medical care unrelated to the person's mental illness and the patient provides a written consent to continue existing mental health treatment under certain conditions. The bill would have exempted facilities that use anxiolytic medications in connection with surgery or for the treatment of side effects of medical care that is unrelated to mental health treatment. The bill would have exempted facilities performing evaluation of the psychological condition of persons who were admitted to the facility solely for obtaining medical care under certain conditions. Negotiations to expand the scope and practicability of these exceptions failed.

SB1966 (Sen. Adriane Johnson/Rep. Rita Mayfield)
Mental Health – Out-of-State Care
Public Act 102-0371
This IHA-supported legislation creates the Interstate Contracts for Mental Health Disorder Treatment Act, the first permanent state law allowing Illinois and Wisconsin to utilize contractual arrangements to transfer involuntarily committed patients in private hospitals to its bordering state for inpatient treatment. These contractual arrangements, or compacts, are between providers and bordering state governmental entities and are voluntary, facilitating interstate placement and better delivery of care. Specifically, mental health facilities located in Boone, DeKalb, DuPage, Kane, Lake, McHenry, and Winnebago counties, may contract with Wisconsin county departments to provide mental health treatment to Wisconsin residents who are subject to involuntary commitment orders for treatment. Illinois facilities are also permitted to secure mental health treatment in Wisconsin for Illinois residents who are subject to involuntary commitment orders for treatment. The new flexibilities do not apply to Wisconsin or Illinois residents who are involved in a criminal proceeding. Contains other provisions concerning involuntary commitment court orders, treatment records, transfers between facilities and required contract provisions.

SB1970 (Sen. Laura Fine /Rep. Jennifer Gong-Gershowitz)
Access to Mental Health Information
Public Act 102-0372
The bill initially required a mental health facility to accept information from a patient's family and friends concerning the recipient's treatment for mental illness, and required disclosure of certain information to certain individuals based on a physician's determination that the patient was unable or unwilling to authorize the disclosure. However, in accordance with provisions equivalent to the Health Insurance Portability and Accountability Act (HIPAA), as passed the bill does not require a mental health facility to accept treatment information from family and friends, nor does it allow disclosures to family and friends under the Mental Health and Developmental Disabilities Confidentiality Act (MHDDCA).

SB2323 (Sen. Sara Feigenholtz/Rep. Stephanie Kifowit)
DCFS – Prohibited Restraints for Youth Transport
Public Act 102-0649
This legislation prohibits the use of chemical, manual, and mechanical restraints on youth in care and youth in the protective custody of DCFS during transport provided or arranged by the Department or its contractors and requires the provision of trauma-sensitive transport. Emergency transportation is exempt from transport limitations related to restraint and court-intervention. To prevent potentially harmful transfer delays, exempts inter-hospital non-emergency transportation. Requires the Department to carry out newly-required discharge planning, and requires development of an individualized, trauma-sensitive transportation plan for any youth when transport is provided to or from a psychiatric hospital or residential treatment center and in other specified circumstances. The

transportation plan must receive court approval and written approval from two DCFS Chief Deputy Directors if the youth is being transported from an out-of-state residential treatment center to a psychiatric hospital in any state, the youth is being transported from a psychiatric hospital to a residential treatment center in Illinois and anticipated travel time is more than 3 hours, or in any circumstance that a court has ordered that the plan be approved by the court. Provides for reporting of any known, alleged, or suspected violation of the prohibition and requires that the Department complete a significant events report for applicable violations.

Billing & Collections and Charity Care

HB1720 (Rep. Deanne Mazzochi)
Patient Billing
Re-referred to House Rules
This bill would have required hospitals, in *all* cases in which an amount billed exceeded $50,000 over a 72 hour period, to provide a copy of all "electronic records" used to generate the charges to the patient or family, within 5 days of billing or the date of the request, whichever is later. Current process is when a patient believes there is an inaccuracy on their hospital bill, can request an audit which would compare the medical record to the itemized hospital bill to ensure everything was billed correctly. If discrepancies are identified, the bill would be adjusted and a new bill issued. The bill did not advance.

HB3232 (Rep. Camille Lilly); SB1840 (Sen. Mattie Hunter/Rep. Camille Lilly)
Community Benefit Act and Hospital Uninsured Patient Discount Act
HB3232 Re-referred to House Rules
SB1840 Public Act 102-0581
These bills amend the Illinois Community Benefits Act and the Hospital Uninsured Patient Discount Act.

Hospital Uninsured Patient Discount Act:

- New definitions;
- Lowering of the threshold to $150 for medically necessary services in urban hospitals;
- Lowering of the maximum collectible amount to 20% of family income;
- Additional information on the financial assistance application related to race, ethnicity, sex, preferred language and complaints;
- Extension of the financial assistance application period to 90 days;
- Allowing a temporary visitor's driver's license to be used for residency verification; and
- Assisting uninsured patients who receive community-based primary care provided by an FQHC or free and charitable clinic and are referred by such to the hospital to apply for public health insurance programs or to apply for hospital financial assistance *when hospital services are scheduled.*

Only hospitals subject to the Illinois Community Benefits Act are subject to the new requirements below. It does not impact investor-owned, government, small (less than 100 beds) or rural hospitals.

Community Benefits Act:

- New definitions;
- Requires the community benefit plan to include activities the hospital is taking to address health equity, reduce disparities and improve community health;
- Public disclosure of their annual community benefit report (does not include audited financials);
  - Additional information included:

- Charity cost by hospital if part of a system and a subset of charity costs provided in the emergency department;
- Net patient revenue by hospital;
- Financial assistance applications statistics including the five most frequent reasons for financial assistance denials; and
- To the extent that race, ethnicity, sex, or preferred language is collected and available for financial assistance applications, the statistics related to financial assistance applications shall be reported by race, ethnicity, sex, and preferred language. Public reporting of this information shall begin with the community benefit report filed on or after July 1, 2022.

The bill was put forth by Cook County President Preckwinkle, the Cook County Health System and patient advocates, with the stated intent to promote transparency and advance health equity. Although IHA supports these goals, there were numerous concerns with many of the provisions as introduced. IHA engaged in negotiations and was able to obtain significant modifications to the bill. A separate member memo is here, which provides information on further specific changes to these Acts. Public Act 102-0581 is effective January 1, 2022, unless otherwise noted.

HB3268 (Rep. Mary Flowers)
Patient Collections
Re-referred to House Rules
This bill would have prohibited a hospital from pursuing debt collection against a patient with an annual household income of $51,000 or less by garnishing wages, seizing moneys from tax returns or action that may result in foreclosure of the patient's home. Illinois laws protect patients from aggressive collection actions and not only would a hospital not take aggressive debt collection against uninsured patients at this income level, many would write off the entire bill. The Illinois Hospital Uninsured Patient Discount Act requires hospitals in urban areas to provide a 100% discount (free) to uninsured patients up to 200% of the federal poverty level (FPL), which is $53,000 for a family of four. It also stipulates that hospitals cannot pursue legal action against an uninsured patient who has demonstrated they cannot meet their financial obligation. The bill did not advance.

HB3421 (Rep. Eva Dina Delgado)
Patient Out-of-Network Billing
Re-referred to House Rules
This bill was intended to prohibit healthcare professionals and providers from billing a patient if the patient "unknowingly and through no fault of his or her own" received care from an out-of-network provider. The newly passed federal No Surprises Act has addressed the concern by protecting the patient in these situations by limiting their cost-sharing to the same level as if they had been in-network. And the Illinois Insurance Code has long included a similar provision that applies to services in the emergency room and from radiology, anesthesiology, pathology and neonatology providers. The bill did not advance.

HB3460 (Rep. Edgar Gonzalez, Jr.)
Patient Billing
Re-referred to House Rules
This bill would have prohibited hospitals from inquiring about a patient's financial status, except for billing purposes, and restrict treating a patient differently based solely on their financial status. A

patient's financial status for non-emergency treatment allows information to be obtained to help the patient obtain health coverage, such as enrolling in Medicaid or the Marketplace products, since coverage and premium support is predicated on the patient's income. Financial conversations may also help the patient in obtaining financial assistance under the Hospital Uninsured Patient Discount Act, which provides for free or discounted care to uninsured patients and eligibility is determined by the family's income. The bill did not advance.

HB3740 (Rep. Jawaharial Williams)
Patient Financial Assistance
Re-referred to House Rules
This bill would have required a hospital that has a Section 15-86 property tax exemption to refer patients who receive treatment in the emergency department to a financial counselor prior to discharge. Hospitals help and guide patients with financial assistance and this legislation was not necessary given the current laws that already require extensive information about the availability of financial assistance and financial counselors. In addition, EMTALA requires that treatment cannot be delayed in order to inquire about method of payment or insurance status, so hospitals will discuss the patient's health coverage at an appropriate time and prior to leaving the emergency department. Hospitals with patient input will determine if the patient could qualify for Medicaid and inform them about the availability of financial assistance. The bill did not advance.

HB3803 (Rep. Dagmara Avelar/Sen. Celina Villanueva)
Charity Care Information
Public Act 102-0504
Amends the Fair Patient Billing Act to require hospitals to proactively offer information on charity care options available to uninsured patients, regardless of their immigration status or residency. The bill as introduced would have also required the hospital to obtain a patient's signature declining charity care if the patient did not intend to access financial assistance. After discussion with the sponsor, this provision was removed. Public Act 102-0504 is effective December 1, 2021. See an IHA member memo for more information.

SB146 (Sen. Laura Murphy)
Patient Billing
Re-referred to Senate Assignments
This bill would have required hospitals to provide another notice to insured patients inquiring whether they had Medicare supplemental or secondary insurance prior to pursuing collection action. IHA explained the hospital process to support and communicate with every patient during the registration and billing process regarding any available healthcare coverage. Medicare also requires hospitals to ask beneficiaries about all insurance that may be available to determine whether Medicare is primary or secondary payer in order to bill accordingly. The bill did not advance.

Certificate of Need

HB2368 (Rep. Lamont Robinson)
Hospital Closures in Impoverished Areas
Referred to House Rules
The legislation would make changes to the Hospital Licensing Act to require any hospital system meeting certain criteria that chooses to close one of its hospitals in a designated impoverished area to repay the hospital access payment received by the closing hospital under the Public Aid Code. The collected funds

would be redistributed to Safety Net Hospitals within a 15-mile radius of the closing hospital. IHA opposed this onerous legislation that threatens healthcare transformation and seeks to receive funds for services already rendered. The bill was not called in committee.

HB3657 (Rep. Lamont Robinson/Sen. Robert Peters); SB656 (Sen. Robert Peters)
Health Facilities Planning Act
HB3657 Referred to Senate Assignments
SB656 Re-referred to Senate Assignments
This legislation would have made significant and onerous changes to the Health Facilities Planning Act, making the process to end a category of service or close a hospital significantly more challenging and costly. Key provisions of the legislation would add significant reporting requirements to the already arduous process, extend the review period of an application to six months, add egregious fines for certain violations of the Act (upwards of $1 million), and create a private right of action against the hospital. IHA strongly opposed this legislation as unworkable and costly, threatening investment in hospitals and healthcare transformation. While a version of the legislation did pass the House, no action was taken on the legislation in the Senate.

EMS

HB2784 (Rep. Kelly Cassidy/Sen. Robert Peters); SB2117 (Sen. Robert Peters)
Community Emergency Services and Support Act (CESSA)
HB2784 Public Act 102-0580
SB2117 Re-referred to Senate Assignments
This bill creates the Community Emergency Services and Support Act (CESSA), which requires providers of emergency services to coordinate with mobile mental and behavioral health services established by the Division of Mental Health to ensure that individuals experiencing mental or behavioral health crises are diverted from hospitalization and instead linked with available community services as appropriate. HB2784 directs the Division of Mental Health to establish and provide oversight to Regional Advisory Committees in each EMS Region to advise on regional issues related to emergency response systems for mental and behavioral health. The EMS Medical Directors Consortium (i.e., Resource Hospital EMS Medical Directors) in each region will be responsible for convening the meetings of the advisory committee.

SB693 (Sen. Melinda Bush/Rep. Deb Conroy)
EMS Systems Transport
Public Act 102-0623
This bill amends the Emergency Medical Services (EMS) Systems Act to allow EMS patients that meet proper criteria to be transported to an EMS System-approved mental health facility or an urgent care/ immediate care facility after consulting with Online Medical Control. This bill also allows for private, non-public ambulance provider agencies to implement alternative staffing models that include an Emergency Medical Responder (EMR) who is responsible for driving the ambulance with a licensed EMT, EMT-Intermediate, EMT-Advanced, Paramedic, or Pre-Hospital RN in the patient compartment providing care to the patient pursuant to the approved EMS-System plan.

SB1541 (Sen. Tony Munoz)
EMS Systems Mental Health
Referred to Senate Assignments

This bill would have amended the Emergency Medical Services (EMS) Systems Act to allow limited EMS System participation by alternative healthcare facilities for mental healthcare provided that the facility was either owned or operated by a hospital, a mental health facility, or a Certified Comprehensive Community Mental Health Center. The bill did not advance.

Insurance & MCOs

HB62 (Rep. Mary Flowers)
Health Care for All Illinois Act
Re-referred to House Rules
This bill would have provided that all Illinois residents are covered under a new state health plan and entitled to all primary, acute and long-term care, dental and vision care with free choice to utilize any provider. Investor-owned hospitals would have been outlawed and investor-owned HMOs and group practices converted to nonprofits. Funding would have come from state appropriations and graduated income contributions from individuals, business and government with negotiations with the federal government for coverage of Medicare beneficiaries. The bill did not advance.

HB711 (Rep. Greg Harris/Sen. Linda Holmes); SB177 (Sen. Linda Holmes)
Prior Authorization Reform Act
HB711 Public Act 102-0409
SB177 Referred to Senate Assignments
The Prior Authorization Reform Act establishes transparency, standardization, continuity of care, and clinical review standards for prior authorization/utilization review programs implemented by Medicaid Managed Care Organizations (MCOs) and state-regulated private health insurance policies, plans, and contracts that are amended, delivered, issued, or renewed on or after the effective date of the Act. The Act mandates that payers provide 60-day written notification to in-network providers of any new or revised prior authorization requirements and make these policies readily available to providers and patients. It also establishes a response time of five days for non-urgent and 48 hours for urgent prior authorization requests. Payers may not revoke, limit, condition, or restrict approvals while they remain valid and must pay for approved services, except in cases of fraud or abuse. In the event an enrollee changes health plans, the new payer must honor any approvals issued by the prior plan for at least 90 days. With certain exceptions, prior authorization requests, as well as appeals of denied requests, submitted by a physician to a health plan must be reviewed by a plan physician who has experience treating patients with the specific condition or treatment for which the request was submitted. Finally, payers must post to their public websites statistics related to prior authorization approvals, denials, and appeals. See an IHA Member Memo for more details.

HB2832 (Rep. Jackie Haas)
MCO Post-payment Audit Limitation
Re-referred to House Rules
This bill would have limited MCO post-payment audits to no later than two years after the claim's payment date to recover an overpayment by recoupment or offset future payments. The legislation also required HFS to explore the availability of, and if reasonably available, procure technology to update the Department's MEDI system in real time for providers and Medicaid managed care organizations. The Insurance Code currently has an 18-month limit on post-payment audits; however, due to how the statute is written, MCOs are able to conduct post-payment audits beyond the 18-month limitation if provided in contracts with providers. Although this bill was never voted out of committee, it allowed for an educational opportunity for legislators to understand a post-payment audit loophole in the current statute.

HB2992 (Rep. Camille Y. Lilly)
Hospital Workforce Insurance
Re-referred to House Rules
This bill would have mandated that hospitals licensed under the Hospital Licensing Act and University of Illinois Hospital Act provide health insurance coverage to their entire workforce. It also required the Department of Insurance to conduct a study to understand the gaps in health insurance coverage for the uninsured and sources of coverage for the insured (e.g., employer-based, health insurance marketplace, etc.). While IHA did not take issue with the study, it strongly opposed the insurance mandate given that it would have singled out hospitals as employers. Moreover, hospitals in Illinois already offer insurance benefits to employees.

HB3308 (Rep. Thaddeus Jones/Sen. Napoleon Harris III); HB3498 (Rep. Deb Conroy/Sen. Mattie Hunter)
Insurance – Telehealth Services
HB3308 Public Act 102-0104
HB3498 Re-Referred to Assignments
This IHA-backed legislation enhances existing law by codifying telehealth coverage and payment parity with in-person services for state-regulated individual and group commercial health insurance policies, while ensuring strong patient and provider protections. Insurers must reimburse in-network healthcare professionals and facilities, including those in tiered networks, on the same basis, in the same manner, and at the same reimbursement rate that would apply to in-person services for telehealth services that meet the same criteria required to bill in-person care. Insurers and providers may voluntarily negotiate alternate reimbursement rates for telehealth services. A 5-year sunset clause is applicable to the reimbursement mandate, excluding mental health and substance use disorder telehealth services. Insurers must cover clinically appropriate, medically necessary telehealth services (real-time audio or audio/video interactions), e-visits (patient portal communications) and virtual check-ins (5-10-minute "live" conversations to prevent an in-person visit) in the same manner as any other benefits covered under the policy. Existing patient and provider protections in the Insurance Code for telehealth services were clarified and broadened, prohibiting insurers from imposing restrictions like geographic or facility restrictions on telehealth services. For a detailed summary of the legislation, see IHA's Member Memo.

SB332 (Sen. Jacqueline Y. Collins/Rep. Dagmara Avelar)
Insurance – Telehealth Provider Information
Public Act 102-0092
This legislation amends the Network Adequacy and Transparency Act to require a network plan to make information available in hard-copy and electronic provider directories about whether a provider (including hospitals) offers the use of telehealth to deliver services for patients when clinically appropriate. The directories must also include the telehealth modalities used by a provider (e.g., real-time audio or audio/video interactions, remote patient monitoring), what types of telehealth services may be provided, and whether a provider has the ability and willingness to include a family caregiver who is in a separate location than the patient if the patient wishes and provides consent. Amendatory language was accepted to permit other information on telehealth use for inclusion in the directories and limit telehealth services listed to those that may be provided (rather than services that are provided). The latter change may reduce the frequency of required provider outreach to a network plan. Hospitals and other providers are required to notify the network plan electronically or in writing of telehealth use and preferences now required for the directories. Effective upon enactment. See IHA's summary.

SB455 (Sen. David Koehler)

20% MCO Clawback
Re-referred to Senate Assignments
This bill would have required HFS to reduce the MCOs capitated payments by 20% during the Public Health Emergency. HFS would have decreased capitated payments on a prorated basis to reflect amounts paid to MCOs before the bill went into effect. Language in the bill would have returned all collected funds to the General Revenue Fund, resulting in the return of Federal Medicaid funds to Federal CMS. The bill did not provide for additional disbursement of funds recovered to providers. Testimony was heard in committee but was never called for a vote.

SB471 (Sen. Laura Fine/Rep. Lindsey LaPointe)
Network Adequacy and Transparency – Behavioral Health
Public Act 102-0144
This IHA-supported legislation requires commercial insurers, Medicaid fee-for-service and managed care programs to ensure timely and proximate access to treatment for behavioral health conditions. Effective upon enactment, beneficiaries in specified metropolitan counties cannot be required to travel longer than 30 minutes or miles from home for outpatient treatment, while beneficiaries in other counties cannot be required to travel longer than 60 minutes or miles from home to receive outpatient treatment. All beneficiaries cannot be required to wait longer than 10 business days for an initial outpatient appointment or 20 days for follow-up treatment, unless the beneficiary or provider voluntarily chooses to schedule an appointment outside of the required time frames. All beneficiaries cannot be required to travel longer than 60 minutes or miles from home for inpatient or residential treatment. If there is no in-network provider or facility available for a patient to receive timely and proximate access to behavioral health treatment, the insurer must provide exceptions to ensure treatment with a provider or at a facility in accordance with those standards. New network adequacy standards for Medicaid MCOs are limited to providers and facilities that are Medicaid certified.

SB2006 (Sen. David Koehler)
Medicaid Managed Care Performance
Re-referred to Senate Assignments
An initiative of IHA, this bill proposed practical reforms to reduce administrative burden and red tape that serve as barriers to care for Medicaid beneficiaries enrolled in MCOs. SB2006 sought to create transparency in the state's contracts with and policy guidance to the MCOs, standardize MCOs' hospital potentially preventable readmission (PPR) programs, and ensure oversight of the MCOs' clinical and payment policies. IHA agreed to hold the bill after obtaining key concessions as part of negotiations with HFS. HFS has since posted to its website a current version of its master contract with the MCOs, including amendments, and managed care program policies issued to the MCOs since the contract was issued in 2018. Prior to this agreement, hospitals did not have access to most of these documents. With respect to PPRs, HFS has directed the MCOs to limit payment penalties to readmissions occurring at the same hospital or hospital within the same system, exclude certain conditions from readmission measures (e.g., behavioral health), and cease the practice of deeming a stay a readmission due to shared discharge planning responsibilities or poor MCO care coordination.

Maternal Health

HB738 (Rep. Mary Flowers/Sen. Patricia Van Pelt)
Alternative Health Care Models – Birthing Centers
Public Act 102-0414

This law, effective immediately, expands the number of birthing centers permitted under the Alternative Health Care Delivery Act to include ten (previously four) in the northeast region of the state, with two specifically allotted for the west and south sides of Chicago, and one for East St. Louis. Through IHA's advocacy efforts attempts for these additional birthing centers to circumvent the Certificate of Need process were removed from the final bill.

HB3401 (Rep. Robyn Gabel/Sen. Cristina Castro)
Midwife Practice Act
Re-referred to Senate Assignments
The legislation creates a licensure process for professional midwives under the Illinois Department of Financial and Professional Regulation. The proposal sets forth standards for professional midwife training, education, and scope of care. IHA was actively engaged in negotiating this legislation and through its joint advocacy efforts with other provider groups secured important provisions related to vicarious liability protection

HB3995 (Rep. Robyn Gabel/Sen. Laura Fine)
Birth Center Licensing
Public Act 102-0518
This law, effective immediately, creates a process by which an independent birth center can be licensed by IDPH. This Act creates minimum staffing requirements, standards, quality of care, reimbursement requirements, reporting requirements, training, and inspection process. Of particular interest to hospitals, birth centers licensed under this Act must have an established agreement with a nearby receiving birthing hospital for timely transfers as well as demonstrate necessity for the birth center by going through the Certificate of Need process, requirements raised by IHA during negotiations of the final legislation. At this time it is unclear how IDPH will reconcile the requirements for birth centers under this Act and the Alternative Health Care Delivery Act.

SB967 (Sen. Cristina Castro/Rep. LaToya Greenwood)
Maternal Health Omnibus Legislation
Amendatory Veto
This major piece of maternal health legislation, supported by IHA, increases insurance coverage for certain types of prenatal and postpartum care, unbundles certain hospital delivery services, and includes greater mental health and substance use coverage for pregnant and postpartum women. The legislation also expands various state programs for high-risk pregnant and postpartum women and children. Finally, the legislation requires birthing hospitals to implement policies to better facilitate continuity of care for women through their pregnancy and up to 12-months postpartum. Through IHA's advocacy efforts, additional regulatory requirements on hospitals were streamlined from those originally proposed. In addition, best practices for hospital policies are to be developed by IDPH and the Illinois Perinatal Quality Collaborative to ensure they were quality focused and consistent statewide. The Governor issued an amendatory veto to correct a technical error in one section's effective date that conflicts with the implementation timeline. A member memo on this legislation can be found here.

Nursing

HB580 (Rep. Mike Zalewski); SB1807 (Sen. Chapin Rose)
Nurse Licensure Compact
HB580 Re-referred to House Rules
SB1807 Re-referred to Senate Assignments

If it had been enacted, this legislation would have amended the Nurse Practice Act to ratify and approve the Nurse Licensure Compact which allows for the issuance of multistate licenses. A multistate license would permit a nurse to practice in Illinois and other compact states and a compact state nurse to practice in Illinois without having to apply for additional practice licenses. It is a comprehensive bill that includes all necessary key provisions and aligns with the legislation enacted in the 34 current compact states. Neither bill advanced.

HB2642 (Rep. Fred Crespo)
Nurse Reporting Time Pay
Re-referred to House Rules
House Bill 2642 would have required hospitals to pay a nurse a minimum of 4 hours at the nurse's regular rate of pay if they report to work and are sent home without working at least half of their full scheduled shift. This bill does not recognize that hospitals already use various practices designed to address low patient census situations that are not foreseeable or predictable. In addition, it would have required hospitals to pay nurses when they are sent home for disciplinary or impairment reasons and would have financially penalized them for most effectively and safely managing to meet patients' needs – which change from hour to hour and shift to shift – with their available human resources. The bill did not advance.

SB2153 (Sen. Sue Rezin/Rep. Michael J. Zalewski)
Nurse Staffing Improvement
Public Act 102-0641
As a better and strategic alternative to nurse patient ratios, this bill amends the Hospital Licensing Act to strengthen the 2007 Nurse Staffing by Patient Acuity law. It becomes effective upon the Governor's signature. IHA's memo on the bill's key provisions can be found here. IHA will be partnering with the American Nurses Association-Illinois and the Illinois Organization of Nursing Leaders to provide educational tools and resources to assist in compliance.

Regulation and Patient Care

HB67 (Rep. Mary Flowers)
Medical Device Safety
Re-referred to House Rules
This legislation would create the Medical Device Safety Act. It would require all medical devices surgically applied or implanted to be under warranty and makes any entity that produces or sells medical devices liable for all costs for the replacement of a defective medical device. The legislation would further require hospitals and ambulatory surgical centers to provide follow-up surgeries to correct any issues related to a defective medical device for no cost even if the hospital or surgical center did not perform the original implantation. IHA opposed this legislation arguing these issues are already addressed via the medical malpractice process. This bill was not called in committee.

HB68 (Rep. Mary Flowers/Sen. Karina Villa)
Female Deaths
Public Act 102-0256
As introduced, this legislation required hospitals to report additional information under the Hospital Report Card Act specific to the number of female deaths, the number of females who died of a "preventable" cause and the number of physicians who received retraining. IHA opposed this legislation as vague with the resulting data unlikely to provide complete or useful information relevant to a

patient's care. Through IHA's advocacy efforts the legislation was tightened in scope and now requires hospitals to report the death of female patients and female patients who died in the hospital related to a preexisting condition of COVID-19. A member memo on this legislation can be found here.

HB69 (Rep. Mary Flowers)
Diagnostic Algorithm
Re-referred to House Rules
This legislation would have required 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 the hospital to notify the patient of the use of diagnostic algorithms and given the option to be treated without the use of algorithms. IHA successfully opposed this legislation as out of scope of both IDPH and DoIT as well as significantly hindering patient care. This legislation was not called in committee.

HB158 (Rep. Camille Lilly/Sen. Mattie Hunter)
Hospital Regulatory Requirements
Public Act 102-0004

This legislation is the healthcare pillar of the four major proposals of the Legislative Black Caucus. Covering a wide array of healthcare-related topics, this omnibus legislation addresses several hospital regulatory requirements. This bill is effective October 24, 2021.

Medical Staff Credentials and Certification: Requires that as part of the medical staff privileging process, a hospital must ask the Illinois Department of Financial and Professional Regulation (IDFPR) for information pertinent to the medical staff member's proper credentials and certifications in addition to their licensure status and disciplinary action.

N95 Mask Requirement: Requires hospitals to provide N95 masks to specific health care professionals and direct care employees or contractual workers, when appropriate due to government policies, guidance, and recommendations of public health and infection control authorities.

Implicit Bias Training: Requires implicit bias training for "health care professionals" as part of their license or registration renewal on or after Jan. 1, 2022. Nothing compels hospitals to offer training to the covered health care professionals.

Legionella Testing: Requires hospitals to develop a policy for testing their water supply for Legionella bacteria. The policy and test results must be made available to IDPH upon request.

Health Facilities Planning Act: Makes several changes to the Health Facilities Planning Act, including: increasing the size of the Board from 9 to 11 members, with one member being a representative of the community with experience on the effect of discontinuing healthcare services or facility closures on the surrounding community; enhancing the Safety Net Impact Statement relating to the material impact on safety net services to include the impact on the community's racial and healthcare disparities; and allowing the Board to defer final action on an application to discontinue a healthcare facility until the latter of July 1, 2021 or the end of the Governor's or Secretary of Health and Human Services (HHS) COVID-19 public health emergency declaration.

Click here to access more detailed information on this law.

HB206 (Rep. Mary Flowers)
Designation of Patient Care Areas
Re-referred to House Rules
The legislation would have required 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 unworkable and a risk to good patient care and the safety of all patients in the hospital. This legislation was not called in committee.

HB214 (Rep. Dan Brady/Sen. Sara Feigenholtz)
Death Certificates
Public Act 102-0257
This legislation expands the list of professionals permitted to sign a death certificate to include advanced practice registered nurses or a certifying health care professional who is a physician or advanced practice registered nurse who, within 12 months prior to the date of the patient's death, was treating or managing treatment of the patient's illness or condition which resulted in the death. IHA supported this initiative to allow for greater flexibilities for the timely signing of a death certificate in the hospital setting. A member memo on this legislation can be found here.

HB291 (Rep. Natalie Manley); SB272 (Sen. Laura Ellman)
Water Quality Assurance Act
HB291 Re-referred to House Rules
SB272 Re-referred to Senate Assignments
This legislation, an initiative of IDPH, would establish a regulatory system in which hospitals and other healthcare facilities would need to maintain their water systems. The legislation calls for the development of policies, procedures, testing, and remediation of a healthcare facility's water for waterborne pathogens. Through IHA's advocacy efforts, provisions of the legislation were changed to ensure the building owner was responsible for the development of a water quality management system in cases of leased space and that in situations in which an outbreak was found at a healthcare facility the Department would certify that the facility was no longer a source of the pathogen once remediation was complete. This legislation was never called for a vote in committee.

HB588 (Rep. Stephanie Kifowit/Sen. Jacqueline Collins)
Human Trafficking Notice
Public Act 102-0131
This legislation amends the Human Trafficking Resource Center Notice Act adding the posting of appropriate notices under the Act to include all restrooms open to the public. Emergency Departments at all general acute care hospitals will need to comply with this new requirement. A member memo on this legislation can be found here.

HB699 (Rep. Barbara Hernandez)
Thyroid Guard Act
Re-referred to House Rules
The legislation would create the Thyroid Guard Act, requiring a healthcare facility that conducts x-rays to have a thyroid guard available and offer its use to a patient unless the guard directly interferes with the ability to obtain the x-ray that was ordered. IHA raised concerns with this legislation as inconsistent with growing literature on the appropriateness and effectiveness of these types of guards for patients.

HB1728 (Rep. Deanne Mazzochi)

Right to Diagnostic Testing
Re-referred to House Rules
The legislation would amend the Medical Patient Rights Act to provide that patients meeting certain criteria had the right to diagnostic tests without the written approval of a physician. The permissibility of this right is based on various age and other categories consistent with current guidelines for these patient populations. IHA opposed this initiative as codifying into statute guidelines that would likely change as science and medicine evolve. Further, concerns were raised about the increased cost of healthcare that could come from patients seeking unnecessary tests without discussions with their healthcare provider. This legislation was called for a committee vote, but failed.

HB2408 (Rep. Marcus Evans/Sen. Cristina Castro)
Fire and Smoker Damper Inspections
Public Act 102-0426
This legislation creates the Fire and Smoke Damper Inspection Act. It sets forth the requirements for inspection and testing of HVAC fire dampers and smoke dampers, including the certifications required for the inspectors and the standards in which the dampers will tested. Through IHA's advocacy efforts, language around frequency of testing for healthcare facilities inconsistent with other regulatory requirements was removed from the final proposal. A member memo on this legislation can be found here.

HB3100 (Rep. Delia Ramirez/Sen. Karina Villa)
ANCRA Implicit Bias
Public Act 102-0604
The legislation amends the Abused and Neglected Child Reporting Act adding to the training required for mandated reporters a section on implicit bias. The implicit bias training is to include a pre-test to assess baseline implicit bias levels, an implicit bias training task, and a post-test to reevaluate bias levels. This training will be developed by the Department Children and Family Services. A member memo on this legislation can be found here.

HB3901 (Rep. Camille Lilly)
State Agency and Grantee Bonus Prohibition
Re-referred to House Rules
This legislation would prohibit state employees and hospital employees from receiving a bonus from state grant dollars. IHA opposed this legislation questioning why hospitals were signaled out in this proposal. This legislation was not called in committee.

HB3147 (Rep. Natalie Manley/Sen. Tom Cullerton)
Patient Contact Policy
Public Act 102-0398
As introduced, the bill required a hospital to facilitate a phone or video call per day at a patient's request. As a result of IHA advocacy, the bill was amended to require each hospital to develop a policy to encourage patients' ability, during a pandemic or public health emergency, to engage with family members throughout the duration of the pandemic or emergency through mechanisms such as phone or video calls. A member memo on this legislation can be found here.

HB3379 (Rep. Deanne Mazzochi)
IDPH Disinfection Innovation
Re-referred to House Rules

This legislation would require IDPH to identify two hospitals with similar levels of hospital-acquired infections over the last 5 years. A pilot program would then be conducted, wherein one of the hospitals would install antimicrobial metallic impregnated material in common surfaces (light switches, door knobs, patient beds, etc.) in rooms where patients are at a high risk of developing hospital-acquired infections. The infection rate in the pilot facility would be monitored for five years, and then compared to the facility that had similar infection levels. It would be reported to the General Assembly and in medical literature whether the infection rate of the pilot hospital decreased using the metallic materials. The bill did not advance.

SB690 (Sen. Laura Murphy)
Metal Detectors
Re-referred to Senate Assignments
This legislation would have required hospitals to have metal detectors at each point of entry. Those entering via ambulance would be exempt from screening. IHA opposed this legislation citing high costs and operational challenges to implement such legislation. Furthermore, IHA argued such legislation would actually put patients at risk who might suffer undue injury while waiting in line for screening. The legislation was not called in committee.

SB1908 (Sen. Julie Morrison/Rep. Angelica Guerrero-Cuellar)
Surgical Smoke Evacuation
Public Act 102-0533
This legislation requires hospitals and ambulatory surgical centers to adopt policies to ensure the elimination of surgical smoke plume by use of a surgical smoke plume evacuation system for each procedure that generates surgical smoke plume. Hospitals and surgical centers must report to IDPH the adoption of their policy within 90 days of enactment of this legislation. A member memo on this legislation can be found here.

Sexual Assault Services

HB1739 (Rep. Maura Hirschauer/Sen. Karina Villa)
Sexual Assault Survivor Notification
Public Act 102-0022
This legislation requires hospitals to provide sexual assault survivors with written notification about the Illinois State Policy Sexual Assault Evidence Collection Kit. Also states that when sexual assault evidence is collected from a survivor, the healthcare provider who collects the evidence must notify the survivor about the tracking system by providing information about the system and the victim's unique log-in information contained within the sexual assault evidence kit or information that has been generated by the sexual assault evidence tracking system. Provides for a 12 month extension, to January 1, 2023, of the January 1, 2022 mandate requiring all treatment hospitals and treatment hospitals with pediatric transfer to have a Qualified Medical Provider (typically a Sexual Assault Nurse Examiner (SANE)) available to provide a medical forensic exam for a sexual assault patient within 90 minutes of their arrival at the hospital. Deletes a January 1, 2022 sunset of a provision that allows an adult survivor to be transferred to the closest treatment hospital, regardless of whether that hospital also treats pediatric patients. Extends by six months to December 31, 2021, a provision in current law to allow approved Federally Qualified Health Centers to provide medical forensic services to sexual assault survivors. See IHA's member memo on this legislation.

SB969 (Sen. Julie Morrison)

Sexual Assault Exam Reimbursement
Re-referred to Senate Assignments
This bill would have increased the reimbursement rate for a sexual assault forensic exam performed for someone who is uninsured or those who receive medical assistance under the Public Aide Code to $750 for an adult survivor and $500 for a pediatric survivor. Also would have allowed a sexual assault survivor to opt out of billing their private insurance provider in a situation where there is a safety and/or confidentiality concern.

SR58 (Sen. Rachelle Crowe)
Child Sexual and Physical Abuse Task Force
Adopted as Amended
Creates a Child Sexual and Physical Abuse Task Force to investigate, assess and make recommendations on the Sexual Assault Survivors Emergency Treatment Act (SASETA) and its implementation to ensure that child development and children's unique medical needs are addressed in the medical response to child sexual abuse in SASETA. The Task Force must report its findings by October 1, 2021.

Legal

HB704 (Rep. Debbie Meyers-Martin /Sen. Michael E. Hastings)
Healthcare Surrogate-Physician
Public Act 102-0182
This bill amends the Health Care Surrogate Act, which currently requires an Illinois license in its definitions of "attending physician," "health care provider," or "qualified physician." The bill removes that requirement by adding the phrase "licensed in the state where the patient is being treated" to each respective definition.

HB714 (Rep. Jennifer Gong-Gershowitz/Sen. Laura Fine)
Evidence-Health Care Records
Public Act 102-0183
This bill amends the Code of Civil Procedure and, in particular, the provisions related to the maximum fees that a health care practitioner, health care facility, or their independent copy service provider could charge for copies of medical records under Illinois law. As introduced, the bill would require attorneys, registered representatives, or organizations supporting a claim for federal veterans' disability benefits, federal Social Security, or Supplemental Security Income benefits to receive free *copies* of medical records. As negotiated, the bill requires attorneys and registered representatives supporting a claim for (1) federal veterans' disability benefits, (2) federal Social Security or Supplemental Security Income benefits, or (3) Aid to the Aged, Blind, or Disabled benefits receive one free *copy* and free updated medical records not included in the original medical record. In addition, the bill includes "registered nurse," "licensed practical nurse," "therapist," and "counselor" explicitly as examples of a "health care practitioner" as defined. A memo on this legislation can be found here.

SB72 (Sen. Don Harmon/Rep. Jay Hoffman)
Civil Proceedings-Prejudgment Interest
Public Act 102-0006
Effective June 21, 2021, Public Act 102-0006 amends the Interest Act to provide that in all actions for personal injury or wrongful death, with certain exceptions, a plaintiff shall recover prejudgment interest on all damages rendered in a judgment at an interest rate of 6% per year. Prejudgment interest applies only in personal injury and wrongful death cases that reach verdict and does not apply to punitive damages, sanctions and attorney fees, or court costs added to a judgment. Interest starts accruing on

the date that a lawsuit is filed except for claims that occurred before the effective date that begin on the date the action is filed or the effective date of the law, whichever is later. If a defendant makes a settlement offer within the first 12 months of a filed lawsuit and the plaintiff rejects it, the value of settlement offer is subtracted from the damages rendered in a judgment before prejudgment interest is calculated. If the settlement offer meets or exceeds the damages rendered in a judgment, no prejudgment interest will apply. Prejudgment interest does not apply to lawsuits filed against the state, a local unit of government, a school district, community college district or any other governmental entity. IHA's memo on the key provisions in Public Act 102-0006 can be found here.