# HB3776

LRB09711944RPM55466b

## 97TH GENERAL ASSEMBLY

## State of Illinois

## 2011 and 2012

### HB3776

by Rep. David Harris

## SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Health Facilities Planning Act. Provides that beginning on the effective date of the amendatory Act the Health Facilities and Services Review Board is hereby dissolved and the terms of its members shall cease. Amends various Acts to make corresponding changes. Effective on on July 1, 2012.

LRB097 11944 RPM 55466 b

A BILL FOR

AN ACT concerning health facilities.

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

Section 5. The Open Meetings Act is amended by changing Section 1.02 as follows:

(5 ILCS 120/1.02) (from Ch. 102, par. 41.02)

Sec. 1.02. For the purposes of this Act:

"Meeting" means any gathering, whether in person or by video or audio conference, telephone call, electronic means (such as, without limitation, electronic mail, electronic chat, and instant messaging), or other means of contemporaneous interactive communication, of a majority of a quorum of the members of a public body held for the purpose of discussing public business or, for a 5-member public body, a quorum of the members of a public body held for the purpose of discussing public business.

Accordingly, for a 5-member public body, 3 members of the body constitute a quorum and the affirmative vote of 3 members is necessary to adopt any motion, resolution, or ordinance, unless a greater number is otherwise required.

"Public body" includes all legislative, executive, administrative or advisory bodies of the State, counties, townships, cities, villages, incorporated towns, school

districts and all other municipal corporations, boards, bureaus, committees or commissions of this State, and any subsidiary bodies of any of the foregoing including but not limited to committees and subcommittees which are supported in whole or in part by tax revenue, or which expend tax revenue, except the General Assembly and committees or commissions thereof. "Public body" includes tourism boards and convention or civic center boards located in counties that are contiguous to the Mississippi River with populations of more than 250,000 but less than 300,000. ~~"Public body" includes the Health Facilities and Services Review Board.~~ "Public body" does not include a child death review team or the Illinois Child Death Review Teams Executive Council established under the Child Death Review Team Act or an ethics commission acting under the State Officials and Employees Ethics Act.

(Source: P.A. 95-245, eff. 8-17-07; 96-31, eff. 6-30-09.)

Section 10. The State Officials and Employees Ethics Act is amended by changing Section 5-50 as follows:

(5 ILCS 430/5-50)

Sec. 5-50. Ex parte communications; special government agents.

(a) This Section applies to ex parte communications made to any agency listed in subsection (e).

(b) "Ex parte communication" means any written or oral

communication by any person that imparts or requests material information or makes a material argument regarding potential action concerning regulatory, quasi-adjudicatory, investment, or licensing matters pending before or under consideration by the agency. "Ex parte communication" does not include the following: (i) statements by a person publicly made in a public forum; (ii) statements regarding matters of procedure and practice, such as format, the number of copies required, the manner of filing, and the status of a matter; and (iii) statements made by a State employee of the agency to the agency head or other employees of that agency.

(b-5) An ex parte communication received by an agency, agency head, or other agency employee from an interested party or his or her official representative or attorney shall promptly be memorialized and made a part of the record.

(c) An ex parte communication received by any agency, agency head, or other agency employee, other than an ex parte communication described in subsection (b-5), shall immediately be reported to that agency's ethics officer by the recipient of the communication and by any other employee of that agency who responds to the communication. The ethics officer shall require that the ex parte communication be promptly made a part of the record. The ethics officer shall promptly file the ex parte communication with the Executive Ethics Commission, including all written communications, all written responses to the communications, and a memorandum prepared by the ethics officer

stating the nature and substance of all oral communications, the identity and job title of the person to whom each communication was made, all responses made, the identity and job title of the person making each response, the identity of each person from whom the written or oral ex parte communication was received, the individual or entity represented by that person, any action the person requested or recommended, and any other pertinent information. The disclosure shall also contain the date of any ex parte communication.

(d) "Interested party" means a person or entity whose rights, privileges, or interests are the subject of or are directly affected by a regulatory, quasi-adjudicatory, investment, or licensing matter.

(e) This Section applies to the following agencies:

Executive Ethics Commission

Illinois Commerce Commission

Educational Labor Relations Board

State Board of Elections

Illinois Gaming Board

~~Health Facilities and Services Review Board~~

Illinois Workers' Compensation Commission

Illinois Labor Relations Board

Illinois Liquor Control Commission

Pollution Control Board

Property Tax Appeal Board

Illinois Racing Board
Illinois Purchased Care Review Board
Department of State Police Merit Board
Motor Vehicle Review Board
Prisoner Review Board
Civil Service Commission
Personnel Review Board for the Treasurer
Merit Commission for the Secretary of State
Merit Commission for the Office of the Comptroller
Court of Claims
Board of Review of the Department of Employment Security
Department of Insurance
Department of Professional Regulation and licensing boards under the Department
Department of Public Health and licensing boards under the Department
Office of Banks and Real Estate and licensing boards under the Office
State Employees Retirement System Board of Trustees
Judges Retirement System Board of Trustees
General Assembly Retirement System Board of Trustees
Illinois Board of Investment
State Universities Retirement System Board of Trustees
Teachers Retirement System Officers Board of Trustees

(f) Any person who fails to (i) report an ex parte communication to an ethics officer, (ii) make information part

of the record, or (iii) make a filing with the Executive Ethics Commission as required by this Section or as required by Section 5-165 of the Illinois Administrative Procedure Act violates this Act.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09.)

Section 15. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois is amended by changing Section 2310-217 as follows:

(20 ILCS 2310/2310-217)

Sec. 2310-217. Center for Comprehensive Health Planning.

(a) The Center for Comprehensive Health Planning ("Center") is hereby created to promote the distribution of health care services and improve the healthcare delivery system in Illinois by establishing a statewide Comprehensive Health Plan and ensuring a predictable, transparent, and efficient Certificate of Need process under the Illinois Health Facilities Planning Act. The objectives of the Comprehensive Health Plan include: to assess existing community resources and determine health care needs; to support safety net services for uninsured and underinsured residents; to promote adequate financing for health care services; and to recognize and respond to changes in community health care needs, including public health emergencies and natural disasters. The Center shall comprehensively assess health and mental health

services; assess health needs with a special focus on the identification of health disparities; identify State-level and regional needs; and make findings that identify the impact of market forces on the access to high quality services for uninsured and underinsured residents. The Center shall conduct a biennial comprehensive assessment of health resources and service needs, including, but not limited to, facilities, clinical services, and workforce; conduct needs assessments using key indicators of population health status and determinations of potential benefits that could occur with certain changes in the health care delivery system; collect and analyze relevant, objective, and accurate data, including health care utilization data; identify issues related to health care financing such as revenue streams, federal opportunities, better utilization of existing resources, development of resources, and incentives for new resource development; evaluate findings by the needs assessments; and annually report to the General Assembly and the public.

The Illinois Department of Public Health shall establish a Center for Comprehensive Health Planning to develop a long-range Comprehensive Health Plan, which Plan shall guide the development of clinical services, facilities, and workforce that meet the health and mental health care needs of this State.

(b) Center for Comprehensive Health Planning.

(1) Responsibilities and duties of the Center include:

(A) (Blank); ~~providing technical assistance to the Health Facilities and Services Review Board to permit that Board to apply relevant components of the Comprehensive Health Plan in its deliberations;~~

(B) attempting to identify unmet health needs and assist in any inter-agency State planning for health resource development;

(C) considering health plans and other related publications that have been developed in Illinois and nationally;

(D) establishing priorities and recommend methods for meeting identified health service, facilities, and workforce needs. Plan recommendations shall be short-term, mid-term, and long-range;

(E) conducting an analysis regarding the availability of long-term care resources throughout the State, using data and plans developed under the Illinois Older Adult Services Act, to adjust existing bed need criteria and standards under the Health Facilities Planning Act for changes in utilization of institutional and non-institutional care options, with special consideration of the availability of the least-restrictive options in accordance with the needs and preferences of persons requiring long-term care; and

(F) considering and recognizing health resource

development projects or information on methods by which a community may receive benefit, that are consistent with health resource needs identified through the comprehensive health planning process.

(2) A Comprehensive Health Planner shall be appointed by the Governor, with the advice and consent of the Senate, to supervise the Center and its staff for a paid 3-year term, subject to review and re-approval every 3 years. The Planner shall receive an annual salary of $120,000, or an amount set by the Compensation Review Board, whichever is greater. The Planner shall prepare a budget for review and approval by the Illinois General Assembly, which shall become part of the annual report available on the Department website.

(c) Comprehensive Health Plan.

(1) The Plan shall be developed with a 5 to 10 year range, and updated every 2 years, or annually, if needed.

(2) Components of the Plan shall include:

(A) an inventory to map the State for growth, population shifts, and utilization of available healthcare resources, using both State-level and regionally defined areas;

(B) an evaluation of health service needs, addressing gaps in service, over-supply, and continuity of care, including an assessment of existing safety net services;

(C) an inventory of health care facility infrastructure, including regulated facilities and services, and unregulated facilities and services, as determined by the Center;

(D) recommendations on ensuring access to care, especially for safety net services, including rural and medically underserved communities; and

(E) an integration between health planning for clinical services, facilities and workforce under the Illinois Health Facilities Planning Act and other health planning laws and activities of the State.

(3) Components of the Plan may include recommendations that will be integrated into any relevant certificate of need review criteria, standards, and procedures.

(d) Within 60 days of receiving the Comprehensive Health Plan, the State Board of Health shall review and comment upon the Plan and any policy change recommendations. The first Plan shall be submitted to the State Board of Health within one year after hiring the Comprehensive Health Planner. The Plan shall be submitted to the General Assembly by the following March 1. The Center and State Board shall hold public hearings on the Plan and its updates. The Center shall permit the public to request the Plan to be updated more frequently to address emerging population and demographic trends.

(e) Current comprehensive health planning data and information about Center funding shall be available to the

public on the Department website.

(f) The Department shall submit to a performance audit of the Center by the Auditor General in order to assess whether progress is being made to develop a Comprehensive Health Plan and whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning.

(Source: P.A. 96-31, eff. 6-30-09.)

Section 20. The Illinois Health Facilities Planning Act is amended by changing Sections 2, 3, 8.5, and 19.5 and by adding Section 2.5 as follows:

(20 ILCS 3960/2) (from Ch. 111 1/2, par. 1152)

(Section scheduled to be repealed on December 31, 2019)

Sec. 2. Purpose of the Act. This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community; (2) that promotes, through the process of comprehensive health planning, the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; (3) that promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet

needs; and (4) that carries out these purposes in coordination with the Center for Comprehensive Health Planning and the Comprehensive Health Plan developed by that Center.

The changes made to this Act by this amendatory Act of the 96th General Assembly are intended to accomplish the following objectives: to improve the financial ability of the public to obtain necessary health services; to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; to maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent; to assure that the reduction and closure of health care services or facilities is performed in an orderly and timely manner, and that these actions are deemed to be in the best interests of the public; and to assess the financial burden to patients caused by unnecessary health care construction and modification. ~~The Health Facilities and Services Review Board must apply the findings from the Comprehensive Health Plan to update review standards and criteria, as well as better identify needs and evaluate applications, and establish mechanisms to support adequate financing of the health care delivery system in Illinois, for the development and preservation of safety net services. The Board must provide written and consistent decisions that are based on the findings from the Comprehensive Health Plan, as well as other issue or subject specific plans,~~

~~recommended by the Center for Comprehensive Health Planning. Policies and procedures must include criteria and standards for plan variations and deviations that must be updated. Evidence-based assessments, projections and decisions will be applied regarding capacity, quality, value and equity in the delivery of health care services in Illinois. The integrity of the Certificate of Need process is ensured through revised ethics and communications procedures. Cost containment and support for safety net services must continue to be central tenets of the Certificate of Need process.~~

(Source: P.A. 96-31, eff. 6-30-09.)

(20 ILCS 3960/2.5 new)

Sec. 2.5. Dissolution; Health Facilities and Services Review Board. Beginning on the effective date of this amendatory Act of the 97th General Assembly the Health Facilities and Services Review Board is hereby dissolved and the terms of its members shall cease.

(20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

(Section scheduled to be repealed on December 31, 2019)

Sec. 3. Definitions. As used in this Act:

"Health care facilities" means and includes the following facilities and organizations:

1. An ambulatory surgical treatment center required to be licensed pursuant to the Ambulatory Surgical Treatment

Center Act;

2. An institution, place, building, or agency required to be licensed pursuant to the Hospital Licensing Act;

3. Skilled and intermediate long term care facilities licensed under the Nursing Home Care Act;

3.5. Skilled and intermediate care facilities licensed under the MR/DD Community Care Act;

4. Hospitals, nursing homes, ambulatory surgical treatment centers, or kidney disease treatment centers maintained by the State or any department or agency thereof;

5. Kidney disease treatment centers, including a free-standing hemodialysis unit required to be licensed under the End Stage Renal Disease Facility Act;

6. An institution, place, building, or room used for the performance of outpatient surgical procedures that is leased, owned, or operated by or on behalf of an out-of-state facility;

7. An institution, place, building, or room used for provision of a health care category of service as defined by the Board, including, but not limited to, cardiac catheterization and open heart surgery; and

8. An institution, place, building, or room used for provision of major medical equipment used in the direct clinical diagnosis or treatment of patients, and whose project cost is in excess of the capital expenditure

minimum.

This Act shall not apply to the construction of any new facility or the renovation of any existing facility located on any campus facility as defined in Section 5-5.8b of the Illinois Public Aid Code, provided that the campus facility encompasses 30 or more contiguous acres and that the new or renovated facility is intended for use by a licensed residential facility.

No federally owned facility shall be subject to the provisions of this Act, nor facilities used solely for healing by prayer or spiritual means.

No facility licensed under the Supportive Residences Licensing Act or the Assisted Living and Shared Housing Act shall be subject to the provisions of this Act.

No facility established and operating under the Alternative Health Care Delivery Act as a children's respite care center alternative health care model demonstration program or as an Alzheimer's Disease Management Center alternative health care model demonstration program shall be subject to the provisions of this Act.

A facility designated as a supportive living facility that is in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code shall not be subject to the provisions of this Act.

This Act does not apply to facilities granted waivers under Section 3-102.2 of the Nursing Home Care Act. However, if a

demonstration project under that Act applies for a certificate of need to convert to a nursing facility, it shall meet the licensure and certificate of need requirements in effect as of the date of application.

This Act does not apply to a dialysis facility that provides only dialysis training, support, and related services to individuals with end stage renal disease who have elected to receive home dialysis. This Act does not apply to a dialysis unit located in a licensed nursing home that offers or provides dialysis-related services to residents with end stage renal disease who have elected to receive home dialysis within the nursing home. ~~The Board, however, may require these dialysis facilities and licensed nursing homes to report statistical information on a quarterly basis to the Board to be used by the Board to conduct analyses on the need for proposed kidney disease treatment centers.~~

This Act shall not apply to the closure of an entity or a portion of an entity licensed under the Nursing Home Care Act or the MR/DD Community Care Act, with the exceptions of facilities operated by a county or Illinois Veterans Homes, that elects to convert, in whole or in part, to an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act.

This Act does not apply to any change of ownership of a healthcare facility that is licensed under the Nursing Home Care Act or the MR/DD Community Care Act, with the exceptions

of facilities operated by a county or Illinois Veterans Homes. Changes of ownership of facilities licensed under the Nursing Home Care Act must meet the requirements set forth in Sections 3-101 through 3-119 of the Nursing Home Care Act.

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups. This Act shall apply to construction or modification and to establishment by such health care facility of such contracted portion which is subject to facility licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any

combination thereof.

"Consumer" means any person other than a person (a) whose major occupation currently involves or whose official capacity within the last 12 months has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

~~"State Board" or "Board" means the Health Facilities and Services Review Board.~~

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum; however, any capital expenditure made by or on behalf of a health care facility for (i) the construction or modification of a facility licensed under the Assisted Living and Shared Housing Act or (ii) a conversion project undertaken in accordance with Section 30 of the Older

Adult Services Act shall be excluded from any obligations under this Act.

"Establish" means the construction of a health care facility or the replacement of an existing facility on another site ~~or the initiation of a category of service as defined by the Board~~.

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of Section 1861(s) of such Act. In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

"Capital Expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any

equipment for a facility or part; and which exceeds the capital expenditure minimum.

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Unless otherwise interdependent, or submitted as one project by the applicant, components of construction or modification undertaken by means of a single construction contract or financed through the issuance of a single debt instrument shall not be grouped together as one project. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means $11,500,000 for projects by hospital applicants, $6,500,000 for applicants for projects related to skilled and intermediate care long-term care facilities licensed under the Nursing Home Care Act, and $3,000,000 for projects by all other applicants, which shall be

annually adjusted to reflect the increase in construction costs due to inflation, for major medical equipment and for all other capital expenditures.

"Non-clinical service area" means an area (i) for the benefit of the patients, visitors, staff, or employees of a health care facility and (ii) not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.

"Areawide" means a major area of the State delineated on a geographic, demographic, and functional basis for health planning and for health service and having within it one or more local areas for health planning and health service. The

term "region", as contrasted with the term "subregion", and the word "area" may be used synonymously with the term "areawide".

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

"Physician" means a person licensed to practice in accordance with the Medical Practice Act of 1987, as amended.

"Licensed health care professional" means a person licensed to practice a health profession under pertinent licensing statutes of the State of Illinois.

"Director" means the Director of the Illinois Department of Public Health.

"Agency" means the Illinois Department of Public Health.

"Alternative health care model" means a facility or program authorized under the Alternative Health Care Delivery Act.

"Out-of-state facility" means a person that is both (i) licensed as a hospital or as an ambulatory surgery center under the laws of another state or that qualifies as a hospital or an ambulatory surgery center under regulations adopted pursuant to the Social Security Act and (ii) not licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, or the Nursing Home Care Act. Affiliates of out-of-state facilities shall be considered out-of-state facilities. Affiliates of Illinois licensed health care facilities 100% owned by an Illinois licensed health care

facility, its parent, or Illinois physicians licensed to practice medicine in all its branches shall not be considered out-of-state facilities. Nothing in this definition shall be construed to include an office or any part of an office of a physician licensed to practice medicine in all its branches in Illinois that is not required to be licensed under the Ambulatory Surgical Treatment Center Act.

"Change of ownership of a health care facility" means a change in the person who has ownership or control of a health care facility's physical plant and capital assets. A change in ownership is indicated by the following transactions: sale, transfer, acquisition, lease, change of sponsorship, or other means of transferring control.

"Related person" means any person that: (i) is at least 50% owned, directly or indirectly, by either the health care facility or a person owning, directly or indirectly, at least 50% of the health care facility; or (ii) owns, directly or indirectly, at least 50% of the health care facility.

"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer.

"Freestanding emergency center" means a facility subject to licensure under Section 32.5 of the Emergency Medical Services (EMS) Systems Act.

(Source: P.A. 95-331, eff. 8-21-07; 95-543, eff. 8-28-07; 95-584, eff. 8-31-07; 95-727, eff. 6-30-08; 95-876, eff.

8-21-08; 96-31, eff. 6-30-09; 96-339, eff. 7-1-10; 96-1000, eff. 7-2-10.)

(20 ILCS 3960/8.5)

(Section scheduled to be repealed on December 31, 2019)

Sec. 8.5. Certificate of exemption for change of ownership of a health care facility; public notice and public hearing.

(a) Upon a finding by the Department of Public Health that an application for a change of ownership is complete, the Department of Public Health shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be ~~posted on the Health Facilities and Services Review Board's web site and~~ sent to the State Representative and State Senator of the district in which the health care facility is located. The Department of Public Health shall not find that an application for change of ownership of a hospital is complete without a signed certification that for a period of 2 years after the change of ownership transaction is effective, the

hospital will not adopt a charity care policy that is more restrictive than the policy in effect during the year prior to the transaction.

For the purposes of this subsection, "newspaper of limited circulation" means a newspaper intended to serve a particular or defined population of a specific geographic area within a Metropolitan Statistical Area such as a municipality, town, village, township, or community area, but does not include publications of professional and trade associations.

(b) If a public hearing is requested, it shall be held at least 15 days but no more than 30 days after the date of publication of the legal notice in the community in which the facility is located. The hearing shall be held in a place of reasonable size and accessibility and a full and complete written transcript of the proceedings shall be made. The applicant shall provide a summary of the proposed change of ownership for distribution at the public hearing.

(Source: P.A. 96-31, eff. 6-30-09.)

(20 ILCS 3960/19.5)

(Section scheduled to be repealed on December 31, 2019 and as provided internally)

Sec. 19.5. Audit. The ~~Twenty-four months after the last member of the 9-member Board is appointed, as required under this amendatory Act of the 96th General Assembly, and 36 months thereafter, the~~ Auditor General shall commence a performance

audit of the Center for Comprehensive Health Planning~~, State Board,~~ and the Certificate of Need processes to determine:

(1) whether progress is being made to develop a Comprehensive Health Plan and whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning;

(2) whether changes to the Certificate of Need processes are being implemented effectively, as well as their impact, if any, on access to safety net services; and

(3) whether fines and settlements are fair, consistent, and in proportion to the degree of violations.

The Auditor General must report on the results of the audit to the General Assembly.

This Section is repealed when the Auditor General files his or her report with the General Assembly.

(Source: P.A. 96-31, eff. 6-30-09.)

Section 25. The Hospital Basic Services Preservation Act is amended by changing Section 15 as follows:

(20 ILCS 4050/15)

Sec. 15. Basic services loans.

(a) Essential community hospitals seeking collateralization of loans under this Act must apply to the ~~Health Facilities and Services Review Board on a form prescribed by the Health Facilities and Services Review Board~~

~~by rule. The Health Facilities and Services Review Board shall review the application and, if it approves the applicant's plan, shall forward the application and its approval to the~~ Hospital Basic Services Review Board on a form prescribed by the Hospital Basic Service Review Board.

(b) Upon receipt of the applicant's application ~~and approval from the Health Facilities and Services Review Board~~, the Hospital Basic Services Review Board shall request from the applicant and the applicant shall submit to the Hospital Basic Services Review Board all of the following information:

(1) A copy of the hospital's last audited financial statement.

(2) The percentage of the hospital's patients each year who are Medicaid patients.

(3) The percentage of the hospital's patients each year who are Medicare patients.

(4) The percentage of the hospital's patients each year who are uninsured.

(5) The percentage of services provided by the hospital each year for which the hospital expected payment but for which no payment was received.

(6) Any other information required by the Hospital Basic Services Review Board by rule.

The Hospital Basic Services Review Board shall review the applicant's original application~~, the approval of the Health Facilities and Services Review Board,~~ and the information

provided by the applicant to the Hospital Basic Services Review Board under this Section and make a recommendation to the State Treasurer to accept or deny the application.

(c) If the Hospital Basic Services Review Board recommends that the application be accepted, the State Treasurer may collateralize the applicant's basic service loan for eligible expenses related to completing, attaining, or upgrading basic services, including, but not limited to, delivery, installation, staff training, and other eligible expenses as defined by the State Treasurer by rule. The total cost for any one project to be undertaken by the applicants shall not exceed $10,000,000 and the amount of each basic services loan collateralized under this Act shall not exceed $5,000,000. Expenditures related to basic service loans shall not exceed the amount available in the Fund necessary to collateralize the loans. The terms of any basic services loan collateralized under this Act must be approved by the State Treasurer in accordance with standards established by the State Treasurer by rule.

(Source: P.A. 96-31, eff. 6-30-09.)

Section 30. The Illinois State Auditing Act is amended by changing Section 3-1 as follows:

(30 ILCS 5/3-1) (from Ch. 15, par. 303-1)

Sec. 3-1. Jurisdiction of Auditor General. The Auditor

General has jurisdiction over all State agencies to make post audits and investigations authorized by or under this Act or the Constitution.

The Auditor General has jurisdiction over local government agencies and private agencies only:

(a) to make such post audits authorized by or under this Act as are necessary and incidental to a post audit of a State agency or of a program administered by a State agency involving public funds of the State, but this jurisdiction does not include any authority to review local governmental agencies in the obligation, receipt, expenditure or use of public funds of the State that are granted without limitation or condition imposed by law, other than the general limitation that such funds be used for public purposes;

(b) to make investigations authorized by or under this Act or the Constitution; and

(c) to make audits of the records of local government agencies to verify actual costs of state-mandated programs when directed to do so by the Legislative Audit Commission at the request of the State Board of Appeals under the State Mandates Act.

In addition to the foregoing, the Auditor General may conduct an audit of the Metropolitan Pier and Exposition Authority, the Regional Transportation Authority, the Suburban Bus Division, the Commuter Rail Division and the Chicago

Transit Authority and any other subsidized carrier when authorized by the Legislative Audit Commission. Such audit may be a financial, management or program audit, or any combination thereof.

The audit shall determine whether they are operating in accordance with all applicable laws and regulations. Subject to the limitations of this Act, the Legislative Audit Commission may by resolution specify additional determinations to be included in the scope of the audit.

In addition to the foregoing, the Auditor General must also conduct a financial audit of the Illinois Sports Facilities Authority's expenditures of public funds in connection with the reconstruction, renovation, remodeling, extension, or improvement of all or substantially all of any existing "facility", as that term is defined in the Illinois Sports Facilities Authority Act.

The Auditor General may also conduct an audit, when authorized by the Legislative Audit Commission, of any hospital which receives 10% or more of its gross revenues from payments from the State of Illinois, Department of Healthcare and Family Services (formerly Department of Public Aid), Medical Assistance Program.

The Auditor General is authorized to conduct financial and compliance audits of the Illinois Distance Learning Foundation and the Illinois Conservation Foundation.

As soon as practical after the effective date of this

amendatory Act of 1995, the Auditor General shall conduct a compliance and management audit of the City of Chicago and any other entity with regard to the operation of Chicago O'Hare International Airport, Chicago Midway Airport and Merrill C. Meigs Field. The audit shall include, but not be limited to, an examination of revenues, expenses, and transfers of funds; purchasing and contracting policies and practices; staffing levels; and hiring practices and procedures. When completed, the audit required by this paragraph shall be distributed in accordance with Section 3-14.

The Auditor General shall conduct a financial and compliance and program audit of distributions from the Municipal Economic Development Fund during the immediately preceding calendar year pursuant to Section 8-403.1 of the Public Utilities Act at no cost to the city, village, or incorporated town that received the distributions.

~~The Auditor General must conduct an audit of the Health Facilities and Services Review Board pursuant to Section 19.5 of the Illinois Health Facilities Planning Act.~~

The Auditor General of the State of Illinois shall annually conduct or cause to be conducted a financial and compliance audit of the books and records of any county water commission organized pursuant to the Water Commission Act of 1985 and shall file a copy of the report of that audit with the Governor and the Legislative Audit Commission. The filed audit shall be open to the public for inspection. The cost of the audit shall

be charged to the county water commission in accordance with Section 6z-27 of the State Finance Act. The county water commission shall make available to the Auditor General its books and records and any other documentation, whether in the possession of its trustees or other parties, necessary to conduct the audit required. These audit requirements apply only through July 1, 2007.

The Auditor General must conduct audits of the Rend Lake Conservancy District as provided in Section 25.5 of the River Conservancy Districts Act.

The Auditor General must conduct financial audits of the Southeastern Illinois Economic Development Authority as provided in Section 70 of the Southeastern Illinois Economic Development Authority Act.

The Auditor General shall conduct a compliance audit in accordance with subsections (d) and (f) of Section 30 of the Innovation Development and Economy Act.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09; 96-939, eff. 6-24-10.)

Section 35. The Alternative Health Care Delivery Act is amended by changing Sections 20, 30, and 36.5 as follows:

(210 ILCS 3/20)

Sec. 20. Board responsibilities. The State Board of Health shall have the responsibilities set forth in this Section.

(a) The Board shall investigate new health care delivery models and recommend to the Governor and the General Assembly, through the Department, those models that should be authorized as alternative health care models for which demonstration programs should be initiated. In its deliberations, the Board shall use the following criteria:

(1) The feasibility of operating the model in Illinois, based on a review of the experience in other states including the impact on health professionals of other health care programs or facilities.

(2) The potential of the model to meet an unmet need.

(3) The potential of the model to reduce health care costs to consumers, costs to third party payors, and aggregate costs to the public.

(4) The potential of the model to maintain or improve the standards of health care delivery in some measurable fashion.

(5) The potential of the model to provide increased choices or access for patients.

(b) The Board shall evaluate and make recommendations to the Governor and the General Assembly, through the Department, regarding alternative health care model demonstration programs established under this Act, at the midpoint and end of the period of operation of the demonstration programs. The report shall include, at a minimum, the following:

(1) Whether the alternative health care models

improved access to health care for their service populations in the State.

(2) The quality of care provided by the alternative health care models as may be evidenced by health outcomes, surveillance reports, and administrative actions taken by the Department.

(3) The cost and cost effectiveness to the public, third-party payors, and government of the alternative health care models, including the impact of pilot programs on aggregate health care costs in the area. In addition to any other information collected by the Board under this Section, the Board shall collect from postsurgical recovery care centers uniform billing data substantially the same as specified in Section 4-2(e) of the Illinois Health Finance Reform Act. To facilitate its evaluation of that data, the Board shall forward a copy of the data to the Illinois Health Care Cost Containment Council. All patient identifiers shall be removed from the data before it is submitted to the Board or Council.

(4) The impact of the alternative health care models on the health care system in that area, including changing patterns of patient demand and utilization, financial viability, and feasibility of operation of service in inpatient and alternative models in the area.

(5) (Blank). ~~The implementation by alternative health care models of any special commitments made during~~

~~application review to the Health Facilities and Services Review Board.~~

(6) The continuation, expansion, or modification of the alternative health care models.

(c) The Board shall advise the Department on the definition and scope of alternative health care models demonstration programs.

(d) In carrying out its responsibilities under this Section, the Board shall seek the advice of other Department advisory boards or committees that may be impacted by the alternative health care model or the proposed model of health care delivery. The Board shall also seek input from other interested parties, which may include holding public hearings.

(e) The Board shall otherwise advise the Department on the administration of the Act as the Board deems appropriate.

(Source: P.A. 96-31, eff. 6-30-09.)

(210 ILCS 3/30)

Sec. 30. Demonstration program requirements. The requirements set forth in this Section shall apply to demonstration programs.

(a) There shall be no more than:

(i) 3 subacute care hospital alternative health care models in the City of Chicago (one of which shall be located on a designated site and shall have been licensed as a hospital under the Illinois Hospital Licensing Act

within the 10 years immediately before the application for a license);

(ii) 2 subacute care hospital alternative health care models in the demonstration program for each of the following areas:

(1) Cook County outside the City of Chicago.

(2) DuPage, Kane, Lake, McHenry, and Will Counties.

(3) Municipalities with a population greater than 50,000 not located in the areas described in item (i) of subsection (a) and paragraphs (1) and (2) of item (ii) of subsection (a); and

(iii) 4 subacute care hospital alternative health care models in the demonstration program for rural areas.

In selecting among applicants for these licenses in rural areas, ~~the Health Facilities and Services Review Board and~~ the Department shall give preference to hospitals that may be unable for economic reasons to provide continued service to the community in which they are located unless the hospital were to receive an alternative health care model license.

(a-5) There shall be no more than the total number of postsurgical recovery care centers with a certificate of need for beds as of January 1, 2008.

(a-10) There shall be no more than a total of 9 children's respite care center alternative health care models in the demonstration program, which shall be located as follows:

(1) Two in the City of Chicago.

(2) One in Cook County outside the City of Chicago.

(3) A total of 2 in the area comprised of DuPage, Kane, Lake, McHenry, and Will counties.

(4) A total of 2 in municipalities with a population of 50,000 or more and not located in the areas described in paragraphs (1), (2), or (3).

(5) A total of 2 in rural areas~~, as defined by the Health Facilities and Services Review Board~~.

No more than one children's respite care model owned and operated by a licensed skilled pediatric facility shall be located in each of the areas designated in this subsection (a-10).

(a-15) There shall be 5 authorized community-based residential rehabilitation center alternative health care models in the demonstration program.

(a-20) There shall be an authorized Alzheimer's disease management center alternative health care model in the demonstration program. The Alzheimer's disease management center shall be located in Will County, owned by a not-for-profit entity, and endorsed by a resolution approved by the county board before the effective date of this amendatory Act of the 91st General Assembly.

(a-25) There shall be no more than 10 birth center alternative health care models in the demonstration program, located as follows:

(1) Four in the area comprising Cook, DuPage, Kane, Lake, McHenry, and Will counties, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(2) Three in municipalities with a population of 50,000 or more not located in the area described in paragraph (1) of this subsection, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(3) Three in rural areas, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

The first 3 birth centers authorized to operate by the Department shall be located in or predominantly serve the residents of a health professional shortage area as determined by the United States Department of Health and Human Services. There shall be no more than 2 birth centers authorized to operate in any single health planning area for obstetric services as determined under the Illinois Health Facilities Planning Act. If a birth center is located outside of a health professional shortage area, (i) the birth center shall be located in a health planning area with a demonstrated need for obstetrical service beds~~, as determined by the Health Facilities and Services Review Board~~ or (ii) there must be a reduction in the existing number of obstetrical service beds in the planning area so that the establishment of the birth center

does not result in an increase in the total number of obstetrical service beds in the health planning area.

(b) (Blank). ~~Alternative health care models, other than a model authorized under subsection (a-10) or (a-20), shall obtain a certificate of need from the Health Facilities and Services Review Board under the Illinois Health Facilities Planning Act before receiving a license by the Department. If, after obtaining its initial certificate of need, an alternative health care delivery model that is a community based residential rehabilitation center seeks to increase the bed capacity of that center, it must obtain a certificate of need from the Health Facilities and Services Review Board before increasing the bed capacity. Alternative health care models in medically underserved areas shall receive priority in obtaining a certificate of need.~~

(c) An alternative health care model license shall be issued for a period of one year and shall be annually renewed if the facility or program is in substantial compliance with the Department's rules adopted under this Act. A licensed alternative health care model that continues to be in substantial compliance after the conclusion of the demonstration program shall be eligible for annual renewals unless and until a different licensure program for that type of health care model is established by legislation., except that a postsurgical recovery care center meeting the following requirements may apply within 3 years after August 25, 2009

(the effective date of Public Act 96-669) for a Certificate of Need permit to operate as a hospital:

(1) (Blank). ~~The postsurgical recovery care center shall apply to the Illinois Health Facilities Planning Board for a Certificate of Need permit to discontinue the postsurgical recovery care center and to establish a hospital.~~

(2) If the postsurgical recovery care center obtains a Certificate of Need permit to operate as a hospital, it shall apply for licensure as a hospital under the Hospital Licensing Act and shall meet all statutory and regulatory requirements of a hospital.

(3) After obtaining licensure as a hospital, any license as an ambulatory surgical treatment center and any license as a post-surgical recovery care center shall be null and void.

(4) The former postsurgical recovery care center that receives a hospital license must seek and use its best efforts to maintain certification under Titles XVIII and XIX of the federal Social Security Act.

The Department may issue a provisional license to any alternative health care model that does not substantially comply with the provisions of this Act and the rules adopted under this Act if (i) the Department finds that the alternative health care model has undertaken changes and corrections which upon completion will render the alternative health care model

in substantial compliance with this Act and rules and (ii) the health and safety of the patients of the alternative health care model will be protected during the period for which the provisional license is issued. The Department shall advise the licensee of the conditions under which the provisional license is issued, including the manner in which the alternative health care model fails to comply with the provisions of this Act and rules, and the time within which the changes and corrections necessary for the alternative health care model to substantially comply with this Act and rules shall be completed.

(d) Alternative health care models shall seek certification under Titles XVIII and XIX of the federal Social Security Act. In addition, alternative health care models shall provide charitable care consistent with that provided by comparable health care providers in the geographic area.

(d-5) (Blank).

(e) Alternative health care models shall, to the extent possible, link and integrate their services with nearby health care facilities.

(f) Each alternative health care model shall implement a quality assurance program with measurable benefits and at reasonable cost.

(Source: P.A. 95-331, eff. 8-21-07; 95-445, eff. 1-1-08; 96-31, eff. 6-30-09; 96-129, eff. 8-4-09; 96-669, eff. 8-25-09; 96-812, eff. 1-1-10; 96-1000, eff. 7-2-10; 96-1071, eff.

7-16-10; 96-1123, eff. 1-1-11; revised 9-16-10.)

(210 ILCS 3/36.5)

Sec. 36.5. Alternative health care models authorized. Notwithstanding any other law to the contrary, alternative health care models described in part 1 of Section 35 shall be licensed ~~without additional consideration by the Health Facilities and Services Review Board~~ if:

(1) an application for such a model was filed with the Health Facilities and Services Review Board prior to September 1, 1994;

(2) (Blank) ~~the application was received by the Health Facilities and Services Review Board and was awarded at least the minimum number of points required for approval by the Board or, if the application was withdrawn prior to Board action, the staff report recommended at least the minimum number of points required for approval by the Board~~; and

(3) the applicant complies with all regulations of the Illinois Department of Public Health to receive a license pursuant to part 1 of Section 35.

(Source: P.A. 96-31, eff. 6-30-09.)

Section 40. The Assisted Living and Shared Housing Act is amended by changing Section 145 as follows:

(210 ILCS 9/145)

Sec. 145. Conversion of facilities. Entities licensed as facilities under the Nursing Home Care Act or the MR/DD Community Care Act may elect to convert to a license under this Act. Any facility that chooses to convert, in whole or in part, shall follow the requirements in the Nursing Home Care Act or the MR/DD Community Care Act, as applicable, and rules promulgated under those Acts regarding voluntary closure and notice to residents. ~~Any conversion of existing beds licensed under the Nursing Home Care Act or the MR/DD Community Care Act to licensure under this Act is exempt from review by the Health Facilities and Services Review Board.~~

(Source: P.A. 96-31, eff. 6-30-09; 96-339, eff. 7-1-10; 96-1000, eff. 7-2-10.)

Section 45. The Emergency Medical Services (EMS) Systems Act is amended by changing Section 32.5 as follows:

(210 ILCS 50/32.5)

Sec. 32.5. Freestanding Emergency Center.

(a) The Department shall issue an annual Freestanding Emergency Center (FEC) license to any facility that has received a permit from the Health Facilities and Services Review Board to establish a Freestanding Emergency Center if the application for the permit has been deemed complete by the Department of Public Health by March 1, 2009, and:

(1) is located: (A) in a municipality with a population of 75,000 or fewer inhabitants; (B) within 20 miles of the hospital that owns or controls the FEC; and (C) within 20 miles of the Resource Hospital affiliated with the FEC as part of the EMS System;

(2) is wholly owned or controlled by an Associate or Resource Hospital, but is not a part of the hospital's physical plant;

(3) meets the standards for licensed FECs, adopted by rule of the Department, including, but not limited to:

(A) facility design, specification, operation, and maintenance standards;

(B) equipment standards; and

(C) the number and qualifications of emergency medical personnel and other staff, which must include at least one board certified emergency physician present at the FEC 24 hours per day.

(4) limits its participation in the EMS System strictly to receiving a limited number of BLS runs by emergency medical vehicles according to protocols developed by the Resource Hospital within the FEC's designated EMS System and approved by the Project Medical Director and the Department;

(5) provides comprehensive emergency treatment services, as defined in the rules adopted by the Department pursuant to the Hospital Licensing Act, 24 hours per day,

on an outpatient basis;

(6) provides an ambulance and maintains on site ambulance services staffed with paramedics 24 hours per day;

(7) (blank);

(8) complies with all State and federal patient rights provisions, including, but not limited to, the Emergency Medical Treatment Act and the federal Emergency Medical Treatment and Active Labor Act;

(9) maintains a communications system that is fully integrated with its Resource Hospital within the FEC's designated EMS System;

(10) reports to the Department any patient transfers from the FEC to a hospital within 48 hours of the transfer plus any other data determined to be relevant by the Department;

(11) submits to the Department, on a quarterly basis, the FEC's morbidity and mortality rates for patients treated at the FEC and other data determined to be relevant by the Department;

(12) does not describe itself or hold itself out to the general public as a full service hospital or hospital emergency department in its advertising or marketing activities;

(13) complies with any other rules adopted by the Department under this Act that relate to FECs;

(14) passes the Department's site inspection for compliance with the FEC requirements of this Act;

(15) (blank) ~~submits a copy of the permit issued by the Health Facilities and Services Review Board indicating that the facility has complied with the Illinois Health Facilities Planning Act with respect to the health services to be provided at the facility~~;

(16) submits an application for designation as an FEC in a manner and form prescribed by the Department by rule; and

(17) pays the annual license fee as determined by the Department by rule.

(a-5) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility that is located in a county that does not have a licensed general acute care hospital if the facility's application for a permit from the Illinois Health Facilities Planning Board has been deemed complete by the Department of Public Health by March 1, 2009 and if the facility complies with the requirements set forth in paragraphs (1) through (17) of subsection (a).

(a-10) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility if the facility has, by March 31, 2009, filed a letter of intent to establish an FEC and if the facility complies with the requirements set forth in paragraphs (1) through (17) of

subsection (a).

(b) The Department shall:

(1) annually inspect facilities of initial FEC applicants and licensed FECs, and issue annual licenses to or annually relicense FECs that satisfy the Department's licensure requirements as set forth in subsection (a);

(2) suspend, revoke, refuse to issue, or refuse to renew the license of any FEC, after notice and an opportunity for a hearing, when the Department finds that the FEC has failed to comply with the standards and requirements of the Act or rules adopted by the Department under the Act;

(3) issue an Emergency Suspension Order for any FEC when the Director or his or her designee has determined that the continued operation of the FEC poses an immediate and serious danger to the public health, safety, and welfare. An opportunity for a hearing shall be promptly initiated after an Emergency Suspension Order has been issued; and

(4) adopt rules as needed to implement this Section.

(Source: P.A. 95-584, eff. 8-31-07; 96-23, eff. 6-30-09; 96-31, eff. 6-30-09; 96-883, eff. 3-1-10; 96-1000, eff. 7-2-10; revised 9-3-10.)

Section 50. The Health Care Worker Self-Referral Act is amended by changing Sections 5, 15, and 20 as follows:

(225 ILCS 47/5)

Sec. 5. Legislative intent. The General Assembly recognizes that patient referrals by health care workers for health services to an entity in which the referring health care worker has an investment interest may present a potential conflict of interest. The General Assembly finds that these referral practices may limit or completely eliminate competitive alternatives in the health care market. In some instances, these referral practices may expand and improve care or may make services available which were previously unavailable. They may also provide lower cost options to patients or increase competition. Generally, referral practices are positive occurrences. However, self-referrals may result in over utilization of health services, increased overall costs of the health care systems, and may affect the quality of health care.

It is the intent of the General Assembly to provide guidance to health care workers regarding acceptable patient referrals, to prohibit patient referrals to entities providing health services in which the referring health care worker has an investment interest, and to protect the citizens of Illinois from unnecessary and costly health care expenditures.

~~Recognizing the need for flexibility to quickly respond to changes in the delivery of health services, to avoid results beyond the limitations on self referral provided under this Act~~

~~and to provide minimal disruption to the appropriate delivery of health care, the Health Facilities and Services Review Board shall be exclusively and solely authorized to implement and interpret this Act through adopted rules.~~

The General Assembly recognizes that changes in delivery of health care has resulted in various methods by which health care workers practice their professions. It is not the intent of the General Assembly to limit appropriate delivery of care, nor force unnecessary changes in the structures created by workers for the health and convenience of their patients.

(Source: P.A. 96-31, eff. 6-30-09.)

(225 ILCS 47/15)

Sec. 15. Definitions. In this Act:

(a) (Blank) ~~"Board" means the Health Facilities and Services Review Board~~.

(b) "Entity" means any individual, partnership, firm, corporation, or other business that provides health services but does not include an individual who is a health care worker who provides professional services to an individual.

(c) "Group practice" means a group of 2 or more health care workers legally organized as a partnership, professional corporation, not-for-profit corporation, faculty practice plan or a similar association in which:

(1) each health care worker who is a member or employee or an independent contractor of the group provides

substantially the full range of services that the health care worker routinely provides, including consultation, diagnosis, or treatment, through the use of office space, facilities, equipment, or personnel of the group;

(2) the services of the health care workers are provided through the group, and payments received for health services are treated as receipts of the group; and

(3) the overhead expenses and the income from the practice are distributed by methods previously determined by the group.

(d) "Health care worker" means any individual licensed under the laws of this State to provide health services, including but not limited to: dentists licensed under the Illinois Dental Practice Act; dental hygienists licensed under the Illinois Dental Practice Act; nurses and advanced practice nurses licensed under the Nurse Practice Act; occupational therapists licensed under the Illinois Occupational Therapy Practice Act; optometrists licensed under the Illinois Optometric Practice Act of 1987; pharmacists licensed under the Pharmacy Practice Act; physical therapists licensed under the Illinois Physical Therapy Act; physicians licensed under the Medical Practice Act of 1987; physician assistants licensed under the Physician Assistant Practice Act of 1987; podiatrists licensed under the Podiatric Medical Practice Act of 1987; clinical psychologists licensed under the Clinical Psychologist Licensing Act; clinical social workers licensed

under the Clinical Social Work and Social Work Practice Act; speech-language pathologists and audiologists licensed under the Illinois Speech-Language Pathology and Audiology Practice Act; or hearing instrument dispensers licensed under the Hearing Instrument Consumer Protection Act, or any of their successor Acts.

(e) "Health services" means health care procedures and services provided by or through a health care worker.

(f) "Immediate family member" means a health care worker's spouse, child, child's spouse, or a parent.

(g) "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments except that investment interest for purposes of Section 20 does not include interest in a hospital licensed under the laws of the State of Illinois.

(h) "Investor" means an individual or entity directly or indirectly owning a legal or beneficial ownership or investment interest, (such as through an immediate family member, trust, or another entity related to the investor).

(i) "Office practice" includes the facility or facilities at which a health care worker, on an ongoing basis, provides or supervises the provision of professional health services to individuals.

(j) "Referral" means any referral of a patient for health

services, including, without limitation:

(1) The forwarding of a patient by one health care worker to another health care worker or to an entity outside the health care worker's office practice or group practice that provides health services.

(2) The request or establishment by a health care worker of a plan of care outside the health care worker's office practice or group practice that includes the provision of any health services.

(Source: P.A. 95-639, eff. 10-5-07; 95-689, eff. 10-29-07; 95-876, eff. 8-21-08; 96-31, eff. 6-30-09.)

(225 ILCS 47/20)

Sec. 20. Prohibited referrals and claims for payment.

(a) A health care worker shall not refer a patient for health services to an entity outside the health care worker's office or group practice in which the health care worker is an investor, unless the health care worker directly provides health services within the entity and will be personally involved with the provision of care to the referred patient.

(b) A ~~Pursuant to Board determination that the following exception is applicable, a~~ health care worker may invest in and refer to an entity, whether or not the health care worker provides direct services within said entity, if there is a demonstrated need in the community for the entity and alternative financing is not available. For purposes of this

subsection (b), "demonstrated need" in the community for the entity may exist if (1) there is no facility of reasonable quality that provides medically appropriate service, (2) use of existing facilities is onerous or creates too great a hardship for patients, or (3) the entity is formed to own or lease medical equipment which replaces obsolete or otherwise inadequate equipment in or under the control of a hospital located in a federally designated health manpower shortage area~~, or (4) such other standards as established, by rule, by the Board~~. "Community" shall be defined as a metropolitan area for a city, and a county for a rural area. In addition, the following provisions must be met to be exempt under this Section:

(1) Individuals who are not in a position to refer patients to an entity are given a bona fide opportunity to also invest in the entity on the same terms as those offered a referring health care worker; and

(2) No health care worker who invests shall be required or encouraged to make referrals to the entity or otherwise generate business as a condition of becoming or remaining an investor; and

(3) The entity shall market or furnish its services to referring health care worker investors and other investors on equal terms; and

(4) The entity shall not loan funds or guarantee any loans for health care workers who are in a position to

refer to an entity; and

(5) The income on the health care worker's investment shall be tied to the health care worker's equity in the facility rather than to the volume of referrals made; and

(6) Any investment contract between the entity and the health care worker shall not include any covenant or non-competition clause that prevents a health care worker from investing in other entities; and

(7) When making a referral, a health care worker must disclose his investment interest in an entity to the patient being referred to such entity. If alternative facilities are reasonably available, the health care worker must provide the patient with a list of alternative facilities. The health care worker shall inform the patient that they have the option to use an alternative facility other than one in which the health care worker has an investment interest and the patient will not be treated differently by the health care worker if the patient chooses to use another entity. This shall be applicable to all health care worker investors, including those who provide direct care or services for their patients in entities outside their office practices; and

(8) If a third party payor requests information with regard to a health care worker's investment interest, the same shall be disclosed; and

(9) The entity shall establish an internal utilization

review program to ensure that investing health care workers provided appropriate or necessary utilization; and

(10) If a health care worker's financial interest in an entity is incompatible with a referred patient's interest, the health care worker shall make alternative arrangements for the patient's care.

~~The Board shall make such a determination for a health care worker within 90 days of a completed written request. Failure to make such a determination within the 90 day time frame shall mean that no alternative is practical based upon the facts set forth in the completed written request.~~

(c) It shall not be a violation of this Act for a health care worker to refer a patient for health services to a publicly traded entity in which he or she has an investment interest provided that:

(1) the entity is listed for trading on the New York Stock Exchange or on the American Stock Exchange, or is a national market system security traded under an automated inter-dealer quotation system operated by the National Association of Securities Dealers; and

(2) the entity had, at the end of the corporation's most recent fiscal year, total net assets of at least $30,000,000 related to the furnishing of health services; and

(3) any investment interest obtained after the effective date of this Act is traded on the exchanges

listed in paragraph 1 of subsection (c) of this Section after the entity became a publicly traded corporation; and

(4) the entity markets or furnishes its services to referring health care worker investors and other health care workers on equal terms; and

(5) all stock held in such publicly traded companies, including stock held in the predecessor privately held company, shall be of one class without preferential treatment as to status or remuneration; and

(6) the entity does not loan funds or guarantee any loans for health care workers who are in a position to be referred to an entity; and

(7) the income on the health care worker's investment is tied to the health care worker's equity in the entity rather than to the volume of referrals made; and

(8) the investment interest does not exceed 1/2 of 1% of the entity's total equity.

(d) Any hospital licensed under the Hospital Licensing Act shall not discriminate against or otherwise penalize a health care worker for compliance with this Act.

(e) Any health care worker or other entity shall not enter into an arrangement or scheme seeking to make referrals to another health care worker or entity based upon the condition that the health care worker or entity will make referrals with an intent to evade the prohibitions of this Act by inducing patient referrals which would be prohibited by this Section if

the health care worker or entity made the referral directly.

(f) If compliance with the need and alternative investor criteria is not practical, the health care worker shall identify to the patient reasonably available alternative facilities. ~~The Board shall, by rule, designate when compliance is "not practical".~~

(g) (Blank). ~~Health care workers may request from the Board that it render an advisory opinion that a referral to an existing or proposed entity under specified circumstances does or does not violate the provisions of this Act. The Board's opinion shall be presumptively correct. Failure to render such an advisory opinion within 90 days of a completed written request pursuant to this Section shall create a rebuttable presumption that a referral described in the completed written request is not or will not be a violation of this Act.~~

(h) Notwithstanding any provision of this Act to the contrary, a health care worker may refer a patient, who is a member of a health maintenance organization "HMO" licensed in this State, for health services to an entity, outside the health care worker's office or group practice, in which the health care worker is an investor, provided that any such referral is made pursuant to a contract with the HMO. Furthermore, notwithstanding any provision of this Act to the contrary, a health care worker may refer an enrollee of a "managed care community network", as defined in subsection (b) of Section 5-11 of the Illinois Public Aid Code, for health

services to an entity, outside the health care worker's office or group practice, in which the health care worker is an investor, provided that any such referral is made pursuant to a contract with the managed care community network.

(Source: P.A. 92-370, eff. 8-15-01.)

(225 ILCS 47/30 rep.)

(225 ILCS 47/35 rep.)

(225 ILCS 47/40 rep.)

Section 52. The Health Care Worker Self-Referral Act is amended by repealing Sections 30, 35, and 40.

Section 55. The Illinois Public Aid Code is amended by changing Section 5-5.02 as follows:

(305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

Sec. 5-5.02. Hospital reimbursements.

(a) Reimbursement to Hospitals; July 1, 1992 through September 30, 1992. Notwithstanding any other provisions of this Code or the Illinois Department's Rules promulgated under the Illinois Administrative Procedure Act, reimbursement to hospitals for services provided during the period July 1, 1992 through September 30, 1992, shall be as follows:

(1) For inpatient hospital services rendered, or if applicable, for inpatient hospital discharges occurring, on or after July 1, 1992 and on or before September 30,

1992, the Illinois Department shall reimburse hospitals for inpatient services under the reimbursement methodologies in effect for each hospital, and at the inpatient payment rate calculated for each hospital, as of June 30, 1992. For purposes of this paragraph, "reimbursement methodologies" means all reimbursement methodologies that pertain to the provision of inpatient hospital services, including, but not limited to, any adjustments for disproportionate share, targeted access, critical care access and uncompensated care, as defined by the Illinois Department on June 30, 1992.

(2) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for targeted access and critical care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period July 1, 1992 through September 30, 1992, shall be 25% of the annual adjustment payments calculated for each eligible hospital, as of June 30, 1992. The Illinois Department shall determine by rule the adjustment payments for targeted access and critical care beginning October 1, 1992.

(3) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for uncompensated care, as defined by the Illinois Department on June 30, 1992, the

adjustment payment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care adjustment payments calculated for each eligible hospital for the uncompensated care rate year, as defined by the Illinois Department, ending on July 31, 1992. The Illinois Department shall determine by rule the adjustment payments for uncompensated care beginning October 1, 1992.

(b) Inpatient payments. For inpatient services provided on or after October 1, 1993, in addition to rates paid for hospital inpatient services pursuant to the Illinois Health Finance Reform Act, as now or hereafter amended, or the Illinois Department's prospective reimbursement methodology, or any other methodology used by the Illinois Department for inpatient services, the Illinois Department shall make adjustment payments, in an amount calculated pursuant to the methodology described in paragraph (c) of this Section, to hospitals that the Illinois Department determines satisfy any one of the following requirements:

(1) Hospitals that are described in Section 1923 of the federal Social Security Act, as now or hereafter amended; or

(2) Illinois hospitals that have a Medicaid inpatient utilization rate which is at least one-half a standard deviation above the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid

payments from the Illinois Department; or

(3) Illinois hospitals that on July 1, 1991 had a Medicaid inpatient utilization rate, as defined in paragraph (h) of this Section, that was at least the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department and which were located in a planning area with one-third or fewer excess beds ~~as determined by the Health Facilities and Services Review Board,~~ and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area; or

(4) Illinois hospitals that:

(A) have a Medicaid inpatient utilization rate that is at least equal to the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department; and

(B) also have a Medicaid obstetrical inpatient utilization rate that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department for obstetrical services; or

(5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children shall be considered a children's hospital to the

degree that the hospital's Medicaid care is provided to children if either (i) the facility devoted exclusively to caring for children is separately licensed as a hospital by a municipality prior to September 30, 1998 or (ii) the hospital has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization rate greater than 55% for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days as defined by the Department in rulemaking.

(c) Inpatient adjustment payments. The adjustment payments required by paragraph (b) shall be calculated based upon the hospital's Medicaid inpatient utilization rate as follows:

(1) hospitals with a Medicaid inpatient utilization rate below the mean shall receive a per day adjustment payment equal to $25;

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

(3) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard

deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

(4) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

(d) Supplemental adjustment payments. In addition to the adjustment payments described in paragraph (c), hospitals as defined in clauses (1) through (5) of paragraph (b), excluding county hospitals (as defined in subsection (c) of Section 15-1 of this Code) and a hospital organized under the University of Illinois Hospital Act, shall be paid supplemental inpatient adjustment payments of $60 per day. For purposes of Title XIX of the federal Social Security Act, these supplemental adjustment payments shall not be classified as adjustment payments to disproportionate share hospitals.

(e) The inpatient adjustment payments described in

paragraphs (c) and (d) shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12 month period for which data are available, or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate. The sum of the inpatient adjustment payments under paragraphs (c) and (d) to a hospital, other than a county hospital (as defined in subsection (c) of Section 15-1 of this Code) or a hospital organized under the University of Illinois Hospital Act, however, shall not exceed $275 per day; that limit shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12-month period for which data are available or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate.

(f) Children's hospital inpatient adjustment payments. For children's hospitals, as defined in clause (5) of paragraph (b), the adjustment payments required pursuant to paragraphs (c) and (d) shall be multiplied by 2.0.

(g) County hospital inpatient adjustment payments. For county hospitals, as defined in subsection (c) of Section 15-1 of this Code, there shall be an adjustment payment as determined by rules issued by the Illinois Department.

(h) For the purposes of this Section the following terms shall be defined as follows:

(1) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, and the denominator of which is the total number of the hospital's inpatient days in that same period.

(2) "Mean Medicaid inpatient utilization rate" means the total number of Medicaid inpatient days provided by all Illinois Medicaid-participating hospitals divided by the total number of inpatient days provided by those same hospitals.

(3) "Medicaid obstetrical inpatient utilization rate" means the ratio of Medicaid obstetrical inpatient days to total Medicaid inpatient days for all Illinois hospitals receiving Medicaid payments from the Illinois Department.

(i) Inpatient adjustment payment limit. In order to meet the limits of Public Law 102-234 and Public Law 103-66, the Illinois Department shall by rule adjust disproportionate share adjustment payments.

(j) University of Illinois Hospital inpatient adjustment payments. For hospitals organized under the University of Illinois Hospital Act, there shall be an adjustment payment as determined by rules adopted by the Illinois Department.

(k) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(Source: P.A. 96-31, eff. 6-30-09.)

Section 60. The Older Adult Services Act is amended by changing Sections 20, 25, and 30 as follows:

(320 ILCS 42/20)

Sec. 20. Priority service areas; service expansion.

(a) The requirements of this Section are subject to the availability of funding.

(b) The Department shall expand older adult services that promote independence and permit older adults to remain in their own homes and communities. Priority shall be given to both the expansion of services and the development of new services in priority service areas.

(c) Inventory of services. The Department shall develop and maintain an inventory and assessment of (i) the types and quantities of public older adult services and, to the extent possible, privately provided older adult services, including the unduplicated count, location, and characteristics of individuals served by each facility, program, or service and (ii) the resources supporting those services.

(d) Priority service areas. The Departments shall assess the current and projected need for older adult services

throughout the State, analyze the results of the inventory, and identify priority service areas, which shall serve as the basis for a priority service plan to be filed with the Governor and the General Assembly no later than July 1, 2006, and every 5 years thereafter.

(e) Moneys appropriated by the General Assembly for the purpose of this Section, receipts from donations, grants, fees, or taxes that may accrue from any public or private sources to the Department for the purpose of this Section, and savings attributable to the nursing home conversion program as calculated in subsection (h) shall be deposited into the Department on Aging State Projects Fund. Interest earned by those moneys in the Fund shall be credited to the Fund.

(f) Moneys described in subsection (e) from the Department on Aging State Projects Fund shall be used for older adult services, regardless of where the older adult receives the service, with priority given to both the expansion of services and the development of new services in priority service areas. Fundable services shall include:

(1) Housing, health services, and supportive services:

(A) adult day care;

(B) adult day care for persons with Alzheimer's disease and related disorders;

(C) activities of daily living;

(D) care-related supplies and equipment;

(E) case management;

(F) community reintegration;

(G) companion;

(H) congregate meals;

(I) counseling and education;

(J) elder abuse prevention and intervention;

(K) emergency response and monitoring;

(L) environmental modifications;

(M) family caregiver support;

(N) financial;

(O) home delivered meals;

(P) homemaker;

(Q) home health;

(R) hospice;

(S) laundry;

(T) long-term care ombudsman;

(U) medication reminders;

(V) money management;

(W) nutrition services;

(X) personal care;

(Y) respite care;

(Z) residential care;

(AA) senior benefits outreach;

(BB) senior centers;

(CC) services provided under the Assisted Living and Shared Housing Act, or sheltered care services that meet the requirements of the Assisted Living and Shared

Housing Act, or services provided under Section 5-5.01a of the Illinois Public Aid Code (the Supportive Living Facilities Program);

(DD) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits;

(EE) training for direct family caregivers;

(FF) transition;

(GG) transportation;

(HH) wellness and fitness programs; and

(II) other programs designed to assist older adults in Illinois to remain independent and receive services in the most integrated residential setting possible for that person.

(2) Older Adult Services Demonstration Grants, pursuant to subsection (g) of this Section.

(g) Older Adult Services Demonstration Grants. The Department shall establish a program of demonstration grants to assist in the restructuring of the delivery system for older adult services and provide funding for innovative service delivery models and system change and integration initiatives. The Department shall prescribe, by rule, the grant application process. At a minimum, every application must include:

(1) The type of grant sought;

(2) A description of the project;

(3) The objective of the project;

(4) The likelihood of the project meeting identified needs;

(5) The plan for financing, administration, and evaluation of the project;

(6) The timetable for implementation;

(7) The roles and capabilities of responsible individuals and organizations;

(8) Documentation of collaboration with other service providers, local community government leaders, and other stakeholders, other providers, and any other stakeholders in the community;

(9) Documentation of community support for the project, including support by other service providers, local community government leaders, and other stakeholders;

(10) The total budget for the project;

(11) The financial condition of the applicant; and

(12) Any other application requirements that may be established by the Department by rule.

Each project may include provisions for a designated staff person who is responsible for the development of the project and recruitment of providers.

Projects may include, but are not limited to: adult family foster care; family adult day care; assisted living in a supervised apartment; personal services in a subsidized housing project; evening and weekend home care coverage; small

incentive grants to attract new providers; money following the person; cash and counseling; managed long-term care; and at least one respite care project that establishes a local coordinated network of volunteer and paid respite workers, coordinates assignment of respite workers to caregivers and older adults, ensures the health and safety of the older adult, provides training for caregivers, and ensures that support groups are available in the community.

A demonstration project funded in whole or in part by an Older Adult Services Demonstration Grant is exempt from the requirements of the Illinois Health Facilities Planning Act. ~~To the extent applicable, however, for the purpose of maintaining the statewide inventory authorized by the Illinois Health Facilities Planning Act, the Department shall send to the Health Facilities and Services Review Board a copy of each grant award made under this subsection (g).~~

The Department, in collaboration with the Departments of Public Health and Healthcare and Family Services, shall evaluate the effectiveness of the projects receiving grants under this Section.

(h) No later than July 1 of each year, the Department of Public Health shall provide information to the Department of Healthcare and Family Services to enable the Department of Healthcare and Family Services to annually document and verify the savings attributable to the nursing home conversion program for the previous fiscal year to estimate an annual amount of

such savings that may be appropriated to the Department on Aging State Projects Fund and notify the General Assembly, the Department on Aging, the Department of Human Services, and the Advisory Committee of the savings no later than October 1 of the same fiscal year.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09.)

(320 ILCS 42/25)

Sec. 25. Older adult services restructuring. No later than January 1, 2005, the Department shall commence the process of restructuring the older adult services delivery system. Priority shall be given to both the expansion of services and the development of new services in priority service areas. Subject to the availability of funding, the restructuring shall include, but not be limited to, the following:

(1) Planning. The Department on Aging and the Departments of Public Health and Healthcare and Family Services shall develop a plan to restructure the State's service delivery system for older adults pursuant to this Act no later than September 30, 2010. The plan shall include a schedule for the implementation of the initiatives outlined in this Act and all other initiatives identified by the participating agencies to fulfill the purposes of this Act and shall protect the rights of all older Illinoisans to services based on their health circumstances and functioning level, regardless of whether they receive their care in their homes, in a community setting,

or in a residential facility. Financing for older adult services shall be based on the principle that "money follows the individual" taking into account individual preference, but shall not jeopardize the health, safety, or level of care of nursing home residents. The plan shall also identify potential impediments to delivery system restructuring and include any known regulatory or statutory barriers.

(2) Comprehensive case management. The Department shall implement a statewide system of holistic comprehensive case management. The system shall include the identification and implementation of a universal, comprehensive assessment tool to be used statewide to determine the level of functional, cognitive, socialization, and financial needs of older adults. This tool shall be supported by an electronic intake, assessment, and care planning system linked to a central location. "Comprehensive case management" includes services and coordination such as (i) comprehensive assessment of the older adult (including the physical, functional, cognitive, psycho-social, and social needs of the individual); (ii) development and implementation of a service plan with the older adult to mobilize the formal and family resources and services identified in the assessment to meet the needs of the older adult, including coordination of the resources and services with any other plans that exist for various formal services, such as hospital discharge plans, and with the information and assistance services; (iii) coordination and monitoring of

formal and family service delivery, including coordination and monitoring to ensure that services specified in the plan are being provided; (iv) periodic reassessment and revision of the status of the older adult with the older adult or, if necessary, the older adult's designated representative; and (v) in accordance with the wishes of the older adult, advocacy on behalf of the older adult for needed services or resources.

(3) Coordinated point of entry. The Department shall implement and publicize a statewide coordinated point of entry using a uniform name, identity, logo, and toll-free number.

(4) Public web site. The Department shall develop a public web site that provides links to available services, resources, and reference materials concerning caregiving, diseases, and best practices for use by professionals, older adults, and family caregivers.

(5) Expansion of older adult services. The Department shall expand older adult services that promote independence and permit older adults to remain in their own homes and communities.

(6) Consumer-directed home and community-based services. The Department shall expand the range of service options available to permit older adults to exercise maximum choice and control over their care.

(7) Comprehensive delivery system. The Department shall expand opportunities for older adults to receive services in systems that integrate acute and chronic care.

(8) Enhanced transition and follow-up services. The Department shall implement a program of transition from one residential setting to another and follow-up services, regardless of residential setting, pursuant to rules with respect to (i) resident eligibility, (ii) assessment of the resident's health, cognitive, social, and financial needs, (iii) development of transition plans, and (iv) the level of services that must be available before transitioning a resident from one setting to another.

(9) Family caregiver support. The Department shall develop strategies for public and private financing of services that supplement and support family caregivers.

(10) Quality standards and quality improvement. The Department shall establish a core set of uniform quality standards for all providers that focus on outcomes and take into consideration consumer choice and satisfaction, and the Department shall require each provider to implement a continuous quality improvement process to address consumer issues. The continuous quality improvement process must benchmark performance, be person-centered and data-driven, and focus on consumer satisfaction.

(11) Workforce. The Department shall develop strategies to attract and retain a qualified and stable worker pool, provide living wages and benefits, and create a work environment that is conducive to long-term employment and career development. Resources such as grants, education, and promotion of career

opportunities may be used.

(12) Coordination of services. The Department shall identify methods to better coordinate service networks to maximize resources and minimize duplication of services and ease of application.

(13) Barriers to services. The Department shall identify barriers to the provision, availability, and accessibility of services and shall implement a plan to address those barriers. The plan shall: (i) identify barriers, including but not limited to, statutory and regulatory complexity, reimbursement issues, payment issues, and labor force issues; (ii) recommend changes to State or federal laws or administrative rules or regulations; (iii) recommend application for federal waivers to improve efficiency and reduce cost and paperwork; (iv) develop innovative service delivery models; and (v) recommend application for federal or private service grants.

(14) Reimbursement and funding. The Department shall investigate and evaluate costs and payments by defining costs to implement a uniform, audited provider cost reporting system to be considered by all Departments in establishing payments. To the extent possible, multiple cost reporting mandates shall not be imposed.

(15) Medicaid nursing home cost containment and Medicare utilization. The Department of Healthcare and Family Services (formerly Department of Public Aid), in collaboration with the Department on Aging and the Department of Public Health and in

consultation with the Advisory Committee, shall propose a plan to contain Medicaid nursing home costs and maximize Medicare utilization. The plan must not impair the ability of an older adult to choose among available services. The plan shall include, but not be limited to, (i) techniques to maximize the use of the most cost-effective services without sacrificing quality and (ii) methods to identify and serve older adults in need of minimal services to remain independent, but who are likely to develop a need for more extensive services in the absence of those minimal services.

(16) Bed reduction. The Department of Public Health shall implement a nursing home conversion program to reduce the number of Medicaid-certified nursing home beds in areas with excess beds. The Department of Healthcare and Family Services shall investigate changes to the Medicaid nursing facility reimbursement system in order to reduce beds. Such changes may include, but are not limited to, incentive payments that will enable facilities to adjust to the restructuring and expansion of services required by the Older Adult Services Act, including adjustments for the voluntary closure or layaway of nursing home beds certified under Title XIX of the federal Social Security Act. Any savings shall be reallocated to fund home-based or community-based older adult services pursuant to Section 20.

(17) Financing. The Department shall investigate and evaluate financing options for older adult services and shall

make recommendations in the report required by Section 15 concerning the feasibility of these financing arrangements. These arrangements shall include, but are not limited to:

(A) private long-term care insurance coverage for older adult services;

(B) enhancement of federal long-term care financing initiatives;

(C) employer benefit programs such as medical savings accounts for long-term care;

(D) individual and family cost-sharing options;

(E) strategies to reduce reliance on government programs;

(F) fraudulent asset divestiture and financial planning prevention; and

(G) methods to supplement and support family and community caregiving.

(18) Older Adult Services Demonstration Grants. The Department shall implement a program of demonstration grants that will assist in the restructuring of the older adult services delivery system, and shall provide funding for innovative service delivery models and system change and integration initiatives pursuant to subsection (g) of Section 20.

(19) (Blank). ~~Bed need methodology update. For the purposes of determining areas with excess beds, the Departments shall provide information and assistance to the Health Facilities and~~

~~Services Review Board to update the Bed Need Methodology for Long-Term Care to update the assumptions used to establish the methodology to make them consistent with modern older adult services.~~

(20) Affordable housing. The Departments shall utilize the recommendations of Illinois' Annual Comprehensive Housing Plan, as developed by the Affordable Housing Task Force through the Governor's Executive Order 2003-18, in their efforts to address the affordable housing needs of older adults.

The Older Adult Services Advisory Committee shall investigate innovative and promising practices operating as demonstration or pilot projects in Illinois and in other states. The Department on Aging shall provide the Older Adult Services Advisory Committee with a list of all demonstration or pilot projects funded by the Department on Aging, including those specified by rule, law, policy memorandum, or funding arrangement. The Committee shall work with the Department on Aging to evaluate the viability of expanding these programs into other areas of the State.

(Source: P.A. 96-31, eff. 6-30-09; 96-248, eff. 8-11-09; 96-1000, eff. 7-2-10.)

(320 ILCS 42/30)

Sec. 30. Nursing home conversion program.

(a) The Department of Public Health, in collaboration with the Department on Aging and the Department of Healthcare and

Family Services, shall establish a nursing home conversion program. Start-up grants, pursuant to subsections (l) and (m) of this Section, shall be made available to nursing homes as appropriations permit as an incentive to reduce certified beds, retrofit, and retool operations to meet new service delivery expectations and demands.

(b) Grant moneys shall be made available for capital and other costs related to: (1) the conversion of all or a part of a nursing home to an assisted living establishment or a special program or unit for persons with Alzheimer's disease or related disorders licensed under the Assisted Living and Shared Housing Act or a supportive living facility established under Section 5-5.01a of the Illinois Public Aid Code; (2) the conversion of multi-resident bedrooms in the facility into single-occupancy rooms; and (3) the development of any of the services identified in a priority service plan that can be provided by a nursing home within the confines of a nursing home or transportation services. Grantees shall be required to provide a minimum of a 20% match toward the total cost of the project.

(c) Nothing in this Act shall prohibit the co-location of services or the development of multifunctional centers under subsection (f) of Section 20, including a nursing home offering community-based services or a community provider establishing a residential facility.

(d) A certified nursing home with at least 50% of its resident population having their care paid for by the Medicaid

program is eligible to apply for a grant under this Section.

(e) Any nursing home receiving a grant under this Section shall reduce the number of certified nursing home beds by a number equal to or greater than the number of beds being converted for one or more of the permitted uses under item (1) or (2) of subsection (b). The nursing home shall retain the Certificate of Need for its nursing and sheltered care beds that were converted for 15 years. If the beds are reinstated by the provider or its successor in interest, the provider shall pay to the fund from which the grant was awarded, on an amortized basis, the amount of the grant. The Department shall establish, by rule, the bed reduction methodology for nursing homes that receive a grant pursuant to item (3) of subsection (b).

(f) Any nursing home receiving a grant under this Section shall agree that, for a minimum of 10 years after the date that the grant is awarded, a minimum of 50% of the nursing home's resident population shall have their care paid for by the Medicaid program. If the nursing home provider or its successor in interest ceases to comply with the requirement set forth in this subsection, the provider shall pay to the fund from which the grant was awarded, on an amortized basis, the amount of the grant.

(g) Before awarding grants, the Department of Public Health shall seek recommendations from the Department on Aging and the Department of Healthcare and Family Services. The Department of

Public Health shall attempt to balance the distribution of grants among geographic regions, and among small and large nursing homes. The Department of Public Health shall develop, by rule, the criteria for the award of grants based upon the following factors:

(1) the unique needs of older adults (including those with moderate and low incomes), caregivers, and providers in the geographic area of the State the grantee seeks to serve;

(2) whether the grantee proposes to provide services in a priority service area;

(3) the extent to which the conversion or transition will result in the reduction of certified nursing home beds in an area with excess beds;

(4) the compliance history of the nursing home; and

(5) any other relevant factors identified by the Department, including standards of need.

(h) A conversion funded in whole or in part by a grant under this Section must not:

(1) diminish or reduce the quality of services available to nursing home residents;

(2) force any nursing home resident to involuntarily accept home-based or community-based services instead of nursing home services;

(3) diminish or reduce the supply and distribution of nursing home services in any community below the level of

need, as defined by the Department by rule; or

(4) cause undue hardship on any person who requires nursing home care.

(i) The Department shall prescribe, by rule, the grant application process. At a minimum, every application must include:

(1) the type of grant sought;

(2) a description of the project;

(3) the objective of the project;

(4) the likelihood of the project meeting identified needs;

(5) the plan for financing, administration, and evaluation of the project;

(6) the timetable for implementation;

(7) the roles and capabilities of responsible individuals and organizations;

(8) documentation of collaboration with other service providers, local community government leaders, and other stakeholders, other providers, and any other stakeholders in the community;

(9) documentation of community support for the project, including support by other service providers, local community government leaders, and other stakeholders;

(10) the total budget for the project;

(11) the financial condition of the applicant; and

(12) any other application requirements that may be established by the Department by rule.

(j) A conversion project funded in whole or in part by a grant under this Section is exempt from the requirements of the Illinois Health Facilities Planning Act. ~~The Department of Public Health, however, shall send to the Health Facilities and Services Review Board a copy of each grant award made under this Section.~~

(k) Applications for grants are public information, except that nursing home financial condition and any proprietary data shall be classified as nonpublic data.

(l) The Department of Public Health may award grants from the Long Term Care Civil Money Penalties Fund established under Section 1919(h)(2)(A)(ii) of the Social Security Act and 42 CFR 488.422(g) if the award meets federal requirements.

(m) The Nursing Home Conversion Fund is created as a special fund in the State treasury. Moneys appropriated by the General Assembly or transferred from other sources for the purposes of this Section shall be deposited into the Fund. All interest earned on moneys in the fund shall be credited to the fund. Moneys contained in the fund shall be used to support the purposes of this Section.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09; 96-758, eff. 8-25-09; 96-1000, eff. 7-2-10.)

(20 ILCS 3960/4 rep.)

(20 ILCS 3960/4.2 rep.)

(20 ILCS 3960/5 rep.)

(20 ILCS 3960/5.4 rep.)

(20 ILCS 3960/6 rep.)

(20 ILCS 3960/12 rep.)

(20 ILCS 3960/12.2 rep.)

(20 ILCS 3960/12.3 rep.)

(20 ILCS 3960/15.1 rep.)

Section 90. The Illinois Health Facilities Planning Act is amended by repealing Sections 4, 4.2, 5, 5.4, 6, 12, 12.2, 12.3, and 15.1.

Section 99. Effective date. This Act takes effect on July 1, 2012.

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20 ILCS 3960/6 rep.

20 ILCS 3960/12 rep.

20 ILCS 3960/12.2 rep.

20 ILCS 3960/12.3 rep.

20 ILCS 3960/15.1 rep.