Rep. Bob Biggins

Filed: 5/2/2008

AMENDMENT TO HOUSE BILL 4699

AMENDMENT NO. _____. Amend House Bill 4699, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Emergency Medical Services (EMS) Systems Act is amended by changing Sections 3.25, 3.30, and 3.200 and by adding Sections 3.1005, 3.1010, 3.1015, 3.1020, 3.1025, 3.1030, 3.1035, 3.1040, and 3.1045 as follows:

(210 ILCS 50/3.25)

Sec. 3.25. EMS Region Plan; Development.

(a) Within 6 months after designation of an EMS Region, an EMS Region Plan addressing at least the information prescribed in Section 3.30 shall be submitted to the Department for approval. The Plan shall be developed by the Region's EMS Medical Directors Committee with advice from the Regional EMS Advisory Committee; portions of the plan concerning trauma

shall be developed jointly with the Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, with advice from the Regional Trauma Advisory Committee, if such Advisory Committee has been established in the Region.

(1) A Region's EMS Medical Directors Committee shall be comprised of the Region's EMS Medical Directors, along with the medical advisor to a fire department vehicle service provider. For regions which include a municipal fire department serving a population of over 2,000,000 people, that fire department's medical advisor shall serve on the Committee. For other regions, the fire department vehicle service providers shall select which medical advisor to serve on the Committee on an annual basis.

(2) A Region's Trauma Center Medical Directors Committee shall be comprised of the Region's Trauma Center Medical Directors.

(b) A Region's Trauma Center Medical Directors may choose to participate in the development of the EMS Region Plan through membership on the Regional EMS Advisory Committee, rather than through a separate Trauma Center Medical Directors Committee. If that option is selected, the Region's Trauma Center Medical Director shall also determine whether a separate Regional Trauma Advisory Committee is necessary for the Region.

(c) In the event of disputes over content of the Plan between the Region's EMS Medical Directors Committee and the

Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, the Director of the Illinois Department of Public Health shall intervene through a mechanism established by the Department through rules adopted pursuant to this Act.

(d) "Regional EMS Advisory Committee" means a committee formed within an Emergency Medical Services (EMS) Region to advise the Region's EMS Medical Directors Committee and to select the Region's representative to the State Emergency Medical Services Advisory Council, consisting of at least the members of the Region's EMS Medical Directors Committee, the Chair of the Regional Trauma Committee, the EMS System Coordinators from each Resource Hospital within the Region, one administrative representative from an Associate Hospital within the Region, one administrative representative from a Participating Hospital within the Region, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within the Region, one administrative representative of a vehicle service provider from each System within the Region, one Emergency Medical Technician (EMT)/Pre-Hospital RN from each level of EMT/Pre-Hospital RN practicing within the Region, ~~and~~ one registered professional nurse currently practicing in an emergency department within the Region, and one neurologist from a Primary Stroke Center. Of the 2 administrative representatives of vehicle service providers, at least one

shall be an administrative representative of a private vehicle service provider. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's EMS Advisory Committee.

Every 2 years, the members of the Region's EMS Medical Directors Committee shall rotate serving as Committee Chair, and select the Associate Hospital, Participating Hospital and vehicle service providers which shall send representatives to the Advisory Committee, and the EMTs/Pre-Hospital RN and nurse who shall serve on the Advisory Committee.

(e) "Regional Trauma Advisory Committee" means a committee formed within an Emergency Medical Services (EMS) Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each Trauma Center within the Region, one EMS Medical Director from a resource hospital within the Region, one EMS System Coordinator from another resource hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative representative from each trauma center within the Region, one EMT representing the highest level of EMT practicing within the Region, one emergency physician and one Trauma Nurse Specialist (TNS) currently practicing in a trauma center. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's Trauma Advisory Committee.

Every 2 years, the members of the Trauma Center Medical Directors Committee shall rotate serving as Committee Chair, and select the vehicle service providers, EMT, emergency physician, EMS System Coordinator and TNS who shall serve on the Advisory Committee.

(Source: P.A. 89-177, eff. 7-19-95.)

(210 ILCS 50/3.30)

Sec. 3.30. EMS Region Plan; Content.

(a) The EMS Medical Directors Committee shall address at least the following:

(1) Protocols for inter-System/inter-Region patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their Department classifications and relevant Regional considerations (e.g. transport times and distances);

(2) Regional standing medical orders;

(3) Patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal;

(4) Protocols for resolving Regional or Inter-System

conflict;

(5) An EMS disaster preparedness plan which includes the actions and responsibilities of all EMS participants within the Region. Within 90 days of the effective date of this amendatory Act of 1996, an EMS System shall submit to the Department for review an internal disaster plan. At a minimum, the plan shall include contingency plans for the transfer of patients to other facilities if an evacuation of the hospital becomes necessary due to a catastrophe, including but not limited to, a power failure;

(6) Regional standardization of continuing education requirements;

(7) Regional standardization of Do Not Resuscitate (DNR) policies, and protocols for power of attorney for health care; ~~and~~

(8) Protocols for disbursement of Department grants; and ~~.~~

(9) Protocols for the triage, treatment, and transport of patients to a Primary Stroke Center.

(b) The Trauma Center Medical Directors or Trauma Center Medical Directors Committee shall address at least the following:

(1) The identification of Regional Trauma Centers;

(2) Protocols for inter-System and inter-Region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the

different levels of emergency department, based on their Department classifications and relevant Regional considerations (e.g. transport times and distances);

(3) Regional trauma standing medical orders;

(4) Trauma patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal;

(5) The identification of which types of patients can be cared for by Level I and Level II Trauma Centers;

(6) Criteria for inter-hospital transfer of trauma patients;

(7) The treatment of trauma patients in each trauma center within the Region;

(8) A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients;

(9) The establishment of a Regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, which shall perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from such reviews to the Department; and

(10) The establishment, within 90 days of the effective date of this amendatory Act of 1996, of an internal disaster plan, which shall include, at a minimum, contingency plans for the transfer of patients to other facilities if an evacuation of the hospital becomes necessary due to a catastrophe, including but not limited to, a power failure.

(c) The Region's EMS Medical Directors and Trauma Center Medical Directors Committees shall appoint any subcommittees which they deem necessary to address specific issues concerning Region activities.

(Source: P.A. 89-177, eff. 7-19-95; 89-667, eff. 1-1-97.)

(210 ILCS 50/3.200)

Sec. 3.200. State Emergency Medical Services Advisory Council.

(a) There shall be established within the Department of Public Health a State Emergency Medical Services Advisory Council, which shall serve as an advisory body to the Department on matters related to this Act.

(b) Membership of the Council shall include one representative from each EMS Region, to be appointed by each region's EMS Regional Advisory Committee. The Governor shall appoint additional members to the Council as necessary to insure that the Council includes one representative from each of the following categories:

(1) EMS Medical Director,

(2) Trauma Center Medical Director,

(3) Licensed, practicing physician with regular and frequent involvement in the provision of emergency care,

(4) Licensed, practicing physician with special expertise in the surgical care of the trauma patient,

(4.5) Neurologist from a Primary Stroke Center,

(5) EMS System Coordinator,

(6) TNS,

(7) EMT-P,

(8) EMT-I,

(9) EMT-B,

(10) Private vehicle service provider,

(11) Law enforcement officer,

(12) Chief of a public vehicle service provider,

(13) Statewide firefighters' union member affiliated with a vehicle service provider,

(14) Administrative representative from a fire department vehicle service provider in a municipality with a population of over 2 million people;

(15) Administrative representative from a Resource Hospital or EMS System Administrative Director.

(c) Of the members first appointed, 5 members shall be appointed for a term of one year, 5 members shall be appointed for a term of 2 years, and the remaining members shall be appointed for a term of 3 years. The terms of subsequent

appointees shall be 3 years. All appointees shall serve until their successors are appointed and qualified.

(d) The Council shall be provided a 90-day period in which to review and comment upon all rules proposed by the Department pursuant to this Act, except for rules adopted pursuant to Section 3.190(a) of this Act, rules submitted to the State Trauma Advisory Council and emergency rules adopted pursuant to Section 5-45 of the Illinois Administrative Procedure Act. The 90-day review and comment period may commence upon the Department's submission of the proposed rules to the individual Council members, if the Council is not meeting at the time the proposed rules are ready for Council review. Any non-emergency rules adopted prior to the Council's 90-day review and comment period shall be null and void. If the Council fails to advise the Department within its 90-day review and comment period, the rule shall be considered acted upon.

(e) Council members shall be reimbursed for reasonable travel expenses incurred during the performance of their duties under this Section.

(f) The Department shall provide administrative support to the Council for the preparation of the agenda and minutes for Council meetings and distribution of proposed rules to Council members.

(g) The Council shall act pursuant to bylaws which it adopts, which shall include the annual election of a Chair and Vice-Chair.

(h) The Director or his designee shall be present at all Council meetings.

(i) Nothing in this Section shall preclude the Council from reviewing and commenting on proposed rules which fall under the purview of the State Trauma Advisory Council.

(Source: P.A. 89-177, eff. 7-19-95; 90-655, eff. 7-30-98.)

(210 ILCS 50/3.1005 new)

Sec. 3.1005. Primary Stroke Center; findings. The General Assembly finds and declares that:

(1) Despite significant advances in diagnosis, treatment, and prevention, stroke remains the third highest killer in the United States. An estimated 700,000 to 750,000 new and recurrent strokes occur each year in this country; and with the aging of the population, the number of persons who have strokes is projected to increase each year. Stroke is the number 3 killer of Illinois residents and leads to the death of more than 7,500 citizens of Illinois each year and disables thousands more. Illinois, Indiana, and Ohio have higher stroke mortality rates than neighboring states Michigan, Minnesota, and Wisconsin.

(2) A level of stroke center and Regional Stroke Center Systems should be established for the treatment of acute stroke. Primary Stroke Centers should be established in acute care hospitals to evaluate, stabilize, and provide

emergency care to patients with acute stroke.

(3) It is in the best interest of the residents of this State to have a program to designate stroke centers throughout the State, to provide specific patient care to ensure that acute stroke patients receive safe and effective care, and to provide financial support to acute care hospitals to maintain and develop stroke centers. Further, it is in the best interest of the people of the State of Illinois to improve the State's emergency medical response to ensure that stroke patients may be quickly identified and transported to and treated in facilities that provide timely and appropriate treatment for stroke patients.

(210 ILCS 50/3.1010 new)

Sec. 3.1010. Primary Stroke Center; definitions. For purposes of Section 3.1005 and the succeeding Sections:

"Department" means the Illinois Department of Public Health.

"Director" means the Director of Public Health.

"Emergency medical services provider" or "EMS provider" means a vehicle service provider which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a Basic Level Support (BLS) Service, Intermediate Life Support (ILS) Service, or Advanced Life Support (ALS) Service level, or any combination thereof,

pursuant to an EMS System program plan submitted to and approved by the Department, and pursuant to the EMS Region Plan adopted for the EMS Region in which the system is located.

"Emergency Medical Services Region" or "EMS Region" means a geographic area designated by the Department that encompasses EMS Systems and trauma centers, in which emergency medical services, trauma centers, and non-emergency medical services are coordinated under an EMS Region Plan.

"Emergency Medical Services System" or "EMS System" means an organization of hospitals, vehicle service providers, and personnel approved by the Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS, or ALS level pursuant to a system program plan submitted to and approved by the Department and pursuant to the EMS Region Plan adopted for the EMS Region in which the EMS System is located.

"Emergency Medical Services Medical Director" or "EMS Medical Director" means the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.

"Primary Stroke Center" means a hospital that has been designated by the Department by any one of the following 3 methods: by the Joint Commission; by another nationally-recognized accrediting body as approved by the Department as qualifying and maintaining conformance with the

requirements of this Act; or by the Department utilizing national-recognized body designation criteria. The Primary Stroke Center shall develop a plan outlining a system of care for stoke victims. This plan shall identify the services associated with stroke prevention, treatment, and rehabilitation such as: primordial and primary prevention; community education; acute stroke treatment, including the hyper acute and emergency department phases; sub-acute stroke treatment and secondary prevention; rehabilitation; and continuous quality improvement (CQI) activities.

"Regional EMS Medical Directors Committee" or "Committee" means a group comprised of the Region's EMS Medical Directors, along with the medical advisor to a fire department vehicle service provider. For Regions that include a municipal fire department serving a population of over 2,000,000 people, that fire department's medical advisor shall serve on the Committee. For other EMS Regions, the fire department vehicle service providers shall select which medical advisor shall serve on the Committee on an annual basis.

"Regional Stroke Center System" means an organization of Primary Stroke Centers, EMS Systems, hospitals, vehicle service providers, and personnel approved by the Department, operating in an established EMS Region, which coordinates and provides pre-hospital, hospital, and inter-hospital care to acute stroke victims.

"Resource Hospital" means the hospital with the authority

and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan.

(210 ILCS 50/3.1015 new)

Sec. 3.1015. Recognition of Primary Stroke Centers.

(a) The Department shall attempt to designate a Primary Stroke Center in all areas of the State. The Department shall authorize State designation status for any hospital that meets any of the following criteria:

(1) The hospital is designated a Primary Stroke Center by the Joint Commission.

(2) The hospital is designated a Primary Stroke Center by a nationally-recognized accrediting body as approved by the Department, provided that the designation criteria of the accrediting body are in keeping with the most recent evidence-based stroke guidelines as determined by national organizations recognized for leadership and expertise in evidence-based practices related to reducing the occurrence, disabilities, and death associated with stroke.

(3) The hospital is designated as a Primary Stroke Center by the Department.

The Department may designate any hospital as a Primary Stroke Center, provided that the Department's criteria for Primary Stroke Center designation reflect the most recent criteria established and are in keeping with the most recent

evidence-based stroke guidelines as determined by national organizations recognized for leadership and expertise in evidence-based practices related to reducing the occurrence, disabilities, and death associated with stroke.

(b) A Primary Stroke Center designation shall be for 2 years. The expiration date from the national designating Primary Stroke Center body shall be adopted by the Department. The Department shall establish the expiration date if the Department makes the primary designation according to criteria set forth in this amendatory Act of the 95th General Assembly. Primary Stoke Centers requesting renewal of their designation must file in writing, with the Department, their request for renewal 60 days prior to the date on which their designation expires. The Department shall re-designate a hospital as a Primary Stroke Center every 2 years.

(c) Each hospital designated a Primary Stroke Center shall notify the Department of its designation within 30 days after receiving that designation. Each hospital shall notify the Department if it ceases to be a Primary Stroke Center, within 30 days after it ceases having that designation.

(d) The Department shall have the authority to inspect designated Primary Stroke Centers to ensure compliance with the provisions of their designation. If the Department determines that a violation has occurred, the Director shall determine the seriousness of the violation and may either suspend or revoke a Primary Stroke Center's designation.

(e) The Department shall have the authority to investigate any complaints made against a Primary Stroke Center and take the following action as appropriate after determining that the Primary Stroke Center is in violation of this Act:

(1) If the Director determines that the violation presents a substantial probability that death or serious physical harm will result and if the stroke center fails to eliminate the violation immediately or within a fixed period of time, the Director may immediately revoke the trauma center designation. The Primary Stroke Center may appeal the revocation within 15 days after receiving the Director's revocation order.

(2) If the Director determines that the violation does not present a substantial probability that death or serious physical harm will result, the Director shall issue a notice of violation and request a plan of correction which shall be subject to the Department approval. The Primary Stroke Center shall have 10 days after the receipt of the notice of violation in which to submit the plan of correction.

(210 ILCS 50/3.1020 new)

Sec. 3.1020. Primary Stroke Center; grants.

(a) In order to encourage and ensure the establishment and retention of Primary Stroke Centers throughout the State, the Director may award matching grants to hospitals that have been

designated Primary Stroke Centers or that seek designation as Primary Stroke Centers, to be used for necessary infrastructure, including personnel and equipment, or to meet the fee requirements for accreditation surveys in order to satisfy the criteria for designation. A matching grant shall not exceed $250,000 or 50% of the hospital's cost for the necessary infrastructure, whichever is less.

(b) The Director may award grant monies to Primary Stroke Centers for the purpose of developing a stroke system.

(c) A Primary Stroke Center or a hospital seeking designation as a Primary Stroke Center may apply to the Director for a matching grant in a manner and form designated by the Director and shall provide information as the Director deems necessary to determine whether the hospital is eligible for the grant.

(d) Matching grant awards shall be made to Primary Stroke Centers or to hospitals seeking designation as a Primary Stroke Center, placing greatest priority on facilities in areas with high stroke morbidity rates and achieving geographic diversity where possible.

(210 ILCS 50/3.1025 new)

Sec. 3.1025. Primary Stroke Center; reporting.

(a) The Director shall, not later than July 1, 2010, prepare and submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a

report indicating the total number of hospitals that have applied for grants under Section 3.1020 of this Act, the project for which the application was submitted, the number of those applicants that have been found eligible for the grants, the total number of grants awarded, the name and address of each grantee, and the amount of the award issued to each grantee.

(b) The Director shall, not later than September 1, 2009, prepare and submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report indicating, as of August 1, 2009, the total number of hospitals that have attained Primary Stroke Center designation and the accrediting bodies through which Primary Stroke Center designations were attained.

(c) By September 1, 2009, the Director shall send the list of designated Primary Stroke Centers to all Resource Hospital EMS Medical Directors in this State and shall post a list of designated Primary Stroke Centers on the Department's website.

(d) The Department shall add Primary Stroke Centers immediately to the website listing upon notice to the Department; any Primary Stroke Center whose designation is revoked shall be removed from the website listing immediately upon notice to the Department.

(e) The Department shall administer a data collection system to collect data reported by Primary Stroke Centers to the Joint Commission or other accrediting body as required to

fulfill Primary Stroke Center designation requirements. The Department shall work with each Primary Stroke Center to capture information using existing electronic reporting tools used for accreditation purposes. Nothing in this Section shall be construed to empower the Department to specify the form of internal recordkeeping. The data collection system and data collected shall comply with the following requirements:

(1) The confidentiality of patient records shall be maintained in accordance with State and federal regulations on the confidentiality of records.

(2) Hospitals shall not be required to submit financial information that is proprietary in nature and unrelated to the scope or purposes of this Act.

(3) Information submitted to the Department shall be privileged and strictly confidential and shall be used only for medical research and the evaluation and improvement of quality care. The identity, or any group of facts that tends to lead to the identity, of any person or facility is confidential and shall not be open to public inspection or dissemination. Data submitted to the Department pursuant to this Act shall not be a public record within the meaning of the Illinois Freedom of Information Act. The Director shall submit standards or guidelines for ensuring the protection of data collected by the Department to the General Assembly for approval pursuant to Section 3.1045 of this Act.

(4) Primary Stroke Centers may provide complete copies of the same reports they submit to the Joint Commission or other accrediting body. The Department shall access this information directly from an accrediting body provided that the Primary Stroke Center has granted the Department permission to do so. The Department shall provide the Primary Stroke Center with a copy of the data received from the accreditation body so the Primary Stroke Center can verify its accuracy.

(5) The aggregate data shall be made available to any and all government agencies or contractors of government agencies that have responsibility for the management and administration of emergency medical services throughout the State.

(6) The Department shall compile the data and report it in aggregate form to be posted annually on its website. The results of this report may be used by the EMS Regions and the Department to conduct training regarding best practices in the treatment of stroke.

(7) The data specific to a Primary Stroke Center shall be made available only if that Primary Stroke Center provides the Department with written authorization for the release of the data.

(210 ILCS 50/3.1030 new)

Sec. 3.1030. Emergency medical services providers; triage

and transportation of a possible acute stroke patient to a Primary Stroke Center.

(a) The Director shall develop a working group to advise the Department on Primary Stoke Center Systems. This work group shall have representation from the following groups: EMS Medical Directors; neurologists from accredited Primary Stroke Centers; EMS Coordinators; the Illinois Fire Chiefs Association; private ambulance providers; and a representative from the State Emergency Medical Services Advisory Council. This group shall also develop and submit a statewide stroke assessment tool to the Department for final approval. Once the tool has been approved, a copy shall be disseminated to all EMS Systems for adoption no later than January 15, 2010. The Director must post this stroke assessment tool on the Department's website. Each EMS System must use a stroke-triage assessment tool that conforms with and is substantially similar to the sample stroke-triage assessment tool provided by the Department.

(b) The Director shall work with EMS System Medical Directors and Regional Stroke Center Systems to establish protocols related to the assessment, treatment, and transport of possible acute stroke patients by licensed emergency medical services providers. These protocols shall include regional transport plans for the triage and transport of possible acute stroke patients to the most appropriate facility, which may include the bypass of health care facilities not designated as

Primary Stroke Centers when it is appropriate to do so.

(c) Each EMS System in the State shall comply with the protocols established by the EMS Region related to the assessment, treatment, and transport of possible acute stroke patients by licensed emergency medical services providers in the State and with all of the Sections of this Act by March 1, 2010.

(d) Each EMS System must address the items described in subsections (a) through (c) of this Section through the established quality improvement and patient outcome reviews as provided in the EMS Region Plan.

(210 ILCS 50/3.1035 new)

Sec. 3.1035. Primary Stroke Center; restricted practices. This Act is not a medical practice guideline and may not be used to restrict the authority of a hospital to provide services for which it has received a license under State law. The General Assembly intends that all patients be treated individually based on each patient's needs and circumstances.

(210 ILCS 50/3.1040 new)

Sec. 3.1040. Primary Stroke Center; authorization to advertise. A person may not claim or advertise to the public, by way of any medium whatsoever, that a hospital is a Primary Stroke Center unless the hospital is designated a Primary Stroke Center in accordance with this Act.

(210 ILCS 50/3.1045 new)

Sec. 3.1045. No authority to make or promulgate rules. Notwithstanding any other rulemaking authority that may exist, neither the Governor nor any agency or agency head under the jurisdiction of the Governor has any authority to make or promulgate rules to implement or enforce the provisions of this amendatory Act of the 95th General Assembly. If, however, the Governor believes that rules are necessary to implement or enforce the provisions of this amendatory Act of the 95th General Assembly, the Governor may suggest rules to the General Assembly by filing them with the Clerk of the House and Secretary of the Senate and by requesting that the General Assembly authorize such rulemaking by law, enact those suggested rules into law, or take any other appropriate action in the General Assembly's discretion. Nothing contained in this amendatory Act of the 95th General Assembly shall be interpreted to grant rulemaking authority under any other Illinois statute where such authority is not otherwise explicitly given. For the purposes of this amendatory Act of the 95th General Assembly, "rules" is given the meaning contained in Section 1-70 of the Illinois Administrative Procedure Act, and "agency" and "agency head" are given the meanings contained in Sections 1-20 and 1-25 of the Illinois Administrative Procedure Act to the extent that such definitions apply to agencies or agency heads under the

jurisdiction of the Governor.

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