

[210 Ill. Comp. Stat. §§ 3/1 through 3/35.]

[§§ 3/1 through 3/35: Alternative Health Care Delivery Act](#)

§ 1. Short title.

This Act may be cited as the Alternative Health Care Delivery Act.

§ 5. Purpose.

The General Assembly finds that many consumers have limited access to needed health care. Other consumers have limited health care choices. Consumers of health care also experience high out-of-pocket costs for health care, and the State as a whole experiences high aggregate health care costs. The General Assembly also finds that the provision of high quality services, regardless of setting, for care is of overriding importance. Currently, there is insufficient data and information on the efficacy of alternative models of health care delivery. New and innovative solutions must be found to correct these problems. This Act is intended to foster those innovations through the development of demonstration projects to license and study alternative health care delivery systems. Furthermore, these demonstration projects shall be developed in an orderly manner and regulated by the Department of Public Health.

§ 10. Definitions.

In this Act, unless the context otherwise requires:

"Ambulatory surgical treatment center" or "ASTC" means any institution, place, or building licensed under the Ambulatory Surgical Treatment Center Act.

"Alternative health care model" means a facility or program authorized under Section 35 of this Act.

"Board" means the State Board of Health.

"Department" means the Illinois Department of Public Health.

"Demonstration program" means a program to license and study alternative health care models authorized under this Act.

"Director" means the Director of Public Health.

§ 15. License required.

No health care facility or program that meets the definition and scope of an alternative health care model shall operate as such unless it is a participant in a demonstration program under this Act and licensed by the Department as an alternative health care model. The provisions of this Act concerning children's community-based health care centers shall not apply to any facility licensed under the Hospital Licensing Act, the Nursing

Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, the MC/DD Act, or the University of Illinois Hospital Act that provides respite care services to children.

§ 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) 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.

§ 25. Department responsibilities.

The Department shall have the responsibilities set forth in this Section.

(a) The Department shall adopt rules for each alternative health care model authorized under this Act that shall include but not be limited to the following:

(1) Further definition of the alternative health care models.

(2) The definition and scope of the demonstration program, including the implementation date and period of operation, not to exceed 5 years.

(3) License application information required by the Department.

(4) The care of patients in the alternative health care models.

(5) Rights afforded to patients of the alternative health care models.

(6) Physical plant requirements.

(7) License application and renewal fees, which may cover the cost of administering the demonstration program.

(8) Information that may be necessary for the Board and the Department to monitor and evaluate the alternative health care model demonstration program.

(9) Administrative fines that may be assessed by the Department for violations of this Act or the rules adopted under this Act.

(b) The Department shall issue, renew, deny, suspend, or revoke licenses for alternative health care models.

(c) The Department shall perform licensure inspections of alternative health care models as deemed necessary by the Department to ensure compliance with this Act or rules.

(d) The Department shall deposit application fees, renewal fees, and fines into the Regulatory Evaluation and Basic Enforcement Fund.

(e) The Department shall assist the Board in performing the Board's responsibilities under this Act.

(f) (Blank).

(g) (Blank).

§ 30. Demonstration program requirements.

The requirements set forth in this Section shall apply to demonstration programs.

(a) (Blank).

(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 community-based health 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 community-based health care center 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) 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) The postsurgical recovery care center shall apply to the Health Facilities and Services Review 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 postsurgical 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.

§ 35. Alternative health care models authorized.

Notwithstanding any other law to the contrary, alternative health care models described in this Section may be established on a demonstration basis.

(1) (Blank).

(2) Alternative health care delivery model; postsurgical recovery care center. A postsurgical recovery care center is a designated site which provides postsurgical recovery care for generally healthy patients undergoing surgical procedures that potentially require overnight nursing care, pain control, or observation that would otherwise be provided in an inpatient setting. Patients may be discharged from the postsurgical recovery care center in less than 24 hours if the attending physician or the facility's medical director believes the patient has recovered enough to be discharged. A postsurgical recovery care center is either freestanding or a defined unit

of an ambulatory surgical treatment center or hospital. No facility, or portion of a facility, may participate in a demonstration program as a postsurgical recovery care center unless the facility has been licensed as an ambulatory surgical treatment center or hospital for at least 2 years before August 20, 1993 (the effective date of Public Act 88-441). The maximum length of stay for patients in a postsurgical recovery care center is not to exceed 48 hours unless the treating physician requests an extension of time from the recovery center's medical director on the basis of medical or clinical documentation that an additional care period is required for the recovery of a patient and the medical director approves the extension of time. In no case, however, shall a patient's length of stay in a postsurgical recovery care center be longer than 72 hours. If a patient requires an additional care period after the expiration of the 72-hour limit, the patient shall be transferred to an appropriate facility. Reports on variances from the 24-hour or 48-hour limit shall be sent to the Department for its evaluation. The reports shall, before submission to the Department, have removed from them all patient and physician identifiers. Blood products may be administered in the postsurgical recovery care center model. In order to handle cases of complications, emergencies, or exigent circumstances, every postsurgical recovery care center as defined in this paragraph shall maintain a contractual relationship, including a transfer agreement, with a general acute care hospital. A postsurgical recovery care center shall be no larger than 20 beds. A postsurgical recovery care center shall be located within 15 minutes travel time from the general acute care hospital with which the center maintains a contractual relationship, including a transfer agreement, as required under this paragraph.

No postsurgical recovery care center shall discriminate against any patient requiring treatment because of the source of payment for services, including Medicare and Medicaid recipients.

The Department shall adopt rules to implement the provisions of Public Act 88-441 concerning postsurgical recovery care centers within 9 months after August 20, 1993. Notwithstanding any other law to the contrary, a postsurgical recovery care center model may provide sleep laboratory or similar sleep studies in accordance with applicable State and federal laws and regulations.

(3) Alternative health care delivery model; children's community-based health care center. A children's community-based health care center model is a designated site that provides nursing care, clinical support services, and therapies for a period of one to 14 days for short-term stays and 120 days to facilitate transitions to home or other appropriate settings for medically fragile children, technology dependent children, and children with special health care needs who are deemed clinically stable by a physician and are younger than 22 years of age. This care is to be provided in a home-like environment that serves no more than 12 children at a time, except that a children's community-based health care center in existence on the effective date of this amendatory Act of the 100th General Assembly that is located in Chicago on grade level for Life Safety Code purposes may provide care to no more than 16 children at a time. Children's community-based health care center services must be available through the model to all families, including those whose care is paid for through the Department of Healthcare and Family Services, the Department of Children and Family Services, the Department of Human Services, and insurance companies who cover home health care services or private duty nursing care in the home.

Each children's community-based health care center model location shall be physically separate and apart from any other facility licensed by the Department of Public Health under this or any other Act and shall provide the following services: respite care, registered nursing or licensed practical nursing care, transitional

care to facilitate home placement or other appropriate settings and reunite families, medical day care, weekend camps, and diagnostic studies typically done in the home setting.

Coverage for the services provided by the Department of Healthcare and Family Services under this paragraph (3) is contingent upon federal waiver approval and is provided only to Medicaid eligible clients participating in the home and community based services waiver designated in Section 1915(c) of the Social Security Act for medically frail and technologically dependent children or children in Department of Children and Family Services foster care who receive home health benefits.

(4) Alternative health care delivery model; community based residential rehabilitation center. A community-based residential rehabilitation center model is a designated site that provides rehabilitation or support, or both, for persons who have experienced severe brain injury, who are medically stable, and who no longer require acute rehabilitative care or intense medical or nursing services. The average length of stay in a community-based residential rehabilitation center shall not exceed 4 months. As an integral part of the services provided, individuals are housed in a supervised living setting while having immediate access to the community. The residential rehabilitation center authorized by the Department may have more than one residence included under the license. A residence may be no larger than 12 beds and shall be located as an integral part of the community. Day treatment or individualized outpatient services shall be provided for persons who reside in their own home. Functional outcome goals shall be established for each individual. Services shall include, but are not limited to, case management, training and assistance with activities of daily living, nursing consultation, traditional therapies (physical, occupational, speech), functional interventions in the residence and community (job placement, shopping, banking, recreation), counseling, self-management strategies, productive activities, and multiple opportunities for skill acquisition and practice throughout the day. The design of individualized program plans shall be consistent with the outcome goals that are established for each resident. The programs provided in this setting shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The program shall have been accredited by CARF as a Brain Injury Community-Integrative Program for at least 3 years.

(5) Alternative health care delivery model; Alzheimer's disease management center. An Alzheimer's disease management center model is a designated site that provides a safe and secure setting for care of persons diagnosed with Alzheimer's disease. An Alzheimer's disease management center model shall be a facility separate from any other facility licensed by the Department of Public Health under this or any other Act. An Alzheimer's disease management center shall conduct and document an assessment of each resident every 6 months. The assessment shall include an evaluation of daily functioning, cognitive status, other medical conditions, and behavioral problems. An Alzheimer's disease management center shall develop and implement an ongoing treatment plan for each resident. The treatment plan shall have defined goals. The Alzheimer's disease management center shall treat behavioral problems and mood disorders using nonpharmacologic approaches such as environmental modification, task simplification, and other appropriate activities. All staff must have necessary training to care for all stages of Alzheimer's Disease. An Alzheimer's disease management center shall provide education and support for residents and caregivers. The education and support shall include referrals to support organizations for educational materials on community resources, support groups, legal and financial issues, respite care, and future care needs and options. The education and support shall also include a discussion of the resident's need to make advance directives and to identify surrogates for medical and legal decision-making. The provisions of this paragraph establish the

minimum level of services that must be provided by an Alzheimer's disease management center. An Alzheimer's disease management center model shall have no more than 100 residents. Nothing in this paragraph (5) shall be construed as prohibiting a person or facility from providing services and care to persons with Alzheimer's disease as otherwise authorized under State law.

(6) Alternative health care delivery model; birth center. A birth center shall be exclusively dedicated to serving the childbirth-related needs of women and their newborns and shall have no more than 10 beds. A birth center is a designated site that is away from the mother's usual place of residence and in which births are planned to occur following a normal, uncomplicated, and low-risk pregnancy. A birth center shall offer prenatal care and community education services and shall coordinate these services with other health care services available in the community.

(A) A birth center shall not be separately licensed if it is one of the following:

(1) A part of a hospital; or

(2) A freestanding facility that is physically distinct from a hospital but is operated under a license issued to a hospital under the Hospital Licensing Act.

(B) A separate birth center license shall be required if the birth center is operated as:

(1) A part of the operation of a federally qualified health center as designated by the United States Department of Health and Human Services; or

(2) A facility other than one described in subparagraph (A)(1), (A)(2), or (B)(1) of this paragraph (6) whose costs are reimbursable under Title XIX of the federal Social Security Act.

In adopting rules for birth centers, the Department shall consider: the American Association of Birth Centers' Standards for Freestanding Birth Centers; the American Academy of Pediatrics/American College of Obstetricians and Gynecologists Guidelines for Perinatal Care; and the Regionalized Perinatal Health Care Code. The Department's rules shall stipulate the eligibility criteria for birth center admission. The Department's rules shall stipulate the necessary equipment for emergency care according to the American Association of Birth Centers' standards and any additional equipment deemed necessary by the Department. The Department's rules shall provide for a time period within which each birth center not part of a hospital must become accredited by either the Commission for the Accreditation of Freestanding Birth Centers or The Joint Commission.

A birth center shall be certified to participate in the Medicare and Medicaid programs under Titles XVIII and XIX, respectively, of the federal Social Security Act. To the extent necessary, the Illinois Department of Healthcare and Family Services shall apply for a waiver from the United States Health Care Financing Administration to allow birth centers to be reimbursed under Title XIX of the federal Social Security Act.

A birth center that is not operated under a hospital license shall be located within a ground travel time distance from the general acute care hospital with which the birth center maintains a contractual relationship, including a transfer agreement, as required under this paragraph, that allows for an emergency caesarian delivery to be started within 30 minutes of the decision a caesarian delivery is necessary. A birth center

operating under a hospital license shall be located within a ground travel time distance from the licensed hospital that allows for an emergency caesarian delivery to be started within 30 minutes of the decision a caesarian delivery is necessary.

The services of a medical director physician, licensed to practice medicine in all its branches, who is certified or eligible for certification by the American College of Obstetricians and Gynecologists or the American Board of Osteopathic Obstetricians and Gynecologists or has hospital obstetrical privileges are required in birth centers. The medical director in consultation with the Director of Nursing and Midwifery Services shall coordinate the clinical staff and overall provision of patient care. The medical director or his or her physician designee shall be available on the premises or within a close proximity as defined by rule. The medical director and the Director of Nursing and Midwifery Services shall jointly develop and approve policies defining the criteria to determine which pregnancies are accepted as normal, uncomplicated, and low-risk, and the anesthesia services available at the center. No general anesthesia may be administered at the center.

If a birth center employs certified nurse midwives, a certified nurse midwife shall be the Director of Nursing and Midwifery Services who is responsible for the development of policies and procedures for services as provided by Department rules.

An obstetrician, family practitioner, or certified nurse midwife shall attend each woman in labor from the time of admission through birth and throughout the immediate postpartum period. Attendance may be delegated only to another physician or certified nurse midwife. Additionally, a second staff person shall also be present at each birth who is licensed or certified in Illinois in a health-related field and under the supervision of the physician or certified nurse midwife in attendance, has specialized training in labor and delivery techniques and care of newborns, and receives planned and ongoing training as needed to perform assigned duties effectively.

The maximum length of stay in a birth center shall be consistent with existing State laws allowing a 48-hour stay or appropriate post-delivery care, if discharged earlier than 48 hours.

A birth center shall participate in the Illinois Perinatal System under the Developmental Disability Prevention Act. At a minimum, this participation shall require a birth center to establish a letter of agreement with a hospital designated under the Perinatal System. A hospital that operates or has a letter of agreement with a birth center shall include the birth center under its maternity service plan under the Hospital Licensing Act and shall include the birth center in the hospital's letter of agreement with its regional perinatal center.

A birth center may not discriminate against any patient requiring treatment because of the source of payment for services, including Medicare and Medicaid recipients.

No general anesthesia and no surgery may be performed at a birth center. The Department may by rule add birth center patient eligibility criteria or standards as it deems necessary. The Department shall by rule require each birth center to report the information which the Department shall make publicly available, which shall include, but is not limited to, the following:

- (i) Birth center ownership.
- (ii) Sources of payment for services.

(iii) Utilization data involving patient length of stay.

(iv) Admissions and discharges.

(v) Complications.

(vi) Transfers.

(vii) Unusual incidents.

(viii) Deaths.

(ix) Any other publicly reported data required under the Illinois Consumer Guide.

(x) Post-discharge patient status data where patients are followed for 14 days after discharge from the birth center to determine whether the mother or baby developed a complication or infection.

Within 9 months after the effective date of this amendatory Act of the 95th General Assembly, the Department shall adopt rules that are developed with consideration of: the American Association of Birth Centers' Standards for Freestanding Birth Centers; the American Academy of Pediatrics/American College of Obstetricians and Gynecologists Guidelines for Perinatal Care; and the Regionalized Perinatal Health Care Code.

The Department shall adopt other rules as necessary to implement the provisions of this amendatory Act of the 95th General Assembly within 9 months after the effective date of this amendatory Act of the 95th General Assembly.