AMITA Health End of Session Advocacy Update

The General Assembly wrapped the Spring legislative session in the early morning hours of June 1 after debating and passing a $42 billion budget as well as legislative redistricting and hundreds of individual bills. AMITA Health was successful on many of our legislative priorities, including telehealth, prior authorization reform and Medicaid funding. The House and Senate are expected back in session in the coming weeks to address several pending items including an energy package and legislation on an elected school board in Chicago.

Below is the status of AMITA Health priority legislation at the close of session. Bills that passed both Chambers must be sent to the Governor within 30 days, the Governor has 60 days to act on each bill. Held bills did not meet legislative deadlines to advance this legislative session. See below for additional detail on passed bills and contact the Director of Government Relations, Julie.Mirostaw@amitahealth.org, with questions.

Bill	Sponsor	Subject	Position	Status
SB 2153	Rezin/Zalewski	Nurse Staffing by Patient Acuity	Support	Passed both chambers
HB 3308	Jones/Harris	Telehealth – negotiated agreement	Support	Passed both chambers
HB 711	Harris/Holmes	Prior Authorization Reform Act	Support	Passed both chambers
HB 2595	Conroy/Fine	Insurance – mental health medical necessity	Support	Passed both Chambers
HB 1776	Harris/Gillespie	DCFS rate – psychiatric stays	Support	Passed both chambers
HB 3657	Robinson/Peters	Health facilities Planning – CON regs	Oppose	Held in Senate Assignments
HB 3871	Crespo	Mandatory Nurse Staffing Ratio	Oppose	Held in House Rules
HB 2642	Crespo	Nurse "reporting time" pay	Oppose	Held in House Rules
SB 1840	Hunter/Lilly	Community Benefit/Financial Assistance Act	Neutral	Passed both chambers
SB 72	Harmon/Hoffman	Prejudgment Interest	Neutral	Signed 5/28, effective 7/1/21

Nurse Staffing by Patient Acuity (SB 2153)

- The Nursing Care Committee must be comprised of at least 55% direct care nurses and its Co-Chair must be a direct care nurse;
- The Nursing Care Committee must produce a hospital-wide staffing plan, including inpatient emergency departments;
- If the staffing plan developed by the Committee is not adopted by the hospital, the Chief Nursing Officer must provide a written explanation of the reasons why and an explanation of the changes that were made to the proposed plan;
- Require the Nursing Care Committee to meet at least six times per year as opposed to once annually, with reports and information from the committee to be provided to direct care nurses;
- Require the Nursing Care Committee to issue an annual report to the Hospital's governing board, including recommendations for future changes to nurse staffing;
- In reviewing the staffing plan, the Nursing Care Committee shall consider issues such as: patient outcomes; complaints related to staffing; the number of nursing hours provided compared to the number of patients

on the unit; aggregate overtime nursing hours worked; the degree to which actual shifts worked varied from what is provided for in the staffing plan;
- Require a mechanism for nurses to report variations from the staffing plan with respect to the assignment of nursing personnel and for a process for such reports to be reviewed and addressed;
- Prohibit any retaliation for any employee who expresses a concern or complaint regarding a violation of the Nurse Staffing by Patient Acuity Act or concerns related to nurse staffing;
- Money from fines for noncompliance will be deposited into the Hospital Licensure Fund and used for scholarships under the Nursing Education Scholarship Law.

Prior Authorization Reform (HB 711)

- Increases transparency, require payers to maintain and publicly post a list of services for which prior authorization is required;
- Establishes important maximum timelines for urgent (48 hours) and non-urgent (5 calendar days) prior authorization requests;
- Defines qualifications of individuals designated to review and make prior authorization determinations;
- Transparency requirements for adverse determinations;
- Ensures that if prior authorization is requested and approved for a given procedure, reasonably related supplies or services are considered to have also received authorization;
- Provides for continuity of care for patients with long-term or chronic conditions by requiring that prior authorization approvals remain in effect for the lesser of 12 months or the course of treatment as recommended by the patient's health care professional or provider;
- Ensures that a prior authorization determination confirms medical necessity (addressed in definitions) requirements and requirements for payment for the delivery of the health care service.

Telehealth (HB 3308)

Commercial Insurance Provisions

- *Reimbursement Parity:* on the same basis, manner and rate that apply to in-person services.
- Does not preclude insurers and providers from voluntarily negotiating alternate reimbursement rates for telehealth services, as long as any agreed upon rates account for ongoing provider investments in telehealth platforms;
- Includes a 5-year sunset clause for reimbursement of physical health services
- Requires the Department of Insurance and the Department of Public Health to commission a study on the efficacy of the coverage and reimbursement parity mandates before the sunset date.
- Coverage Parity Mandate: Insurers must cover clinically appropriate, medically necessary telehealth services (real-time audio or audio/video interactions), e-visits (patient portal communications) and virtual check-ins (5-10-minute "live" conversations to prevent an in-person visit) in the same manner as any other benefits covered under the policy.
- Patient and Provider Protections: Specifically, insurers are prohibited from:
    - Requiring in-person contact occur between a healthcare professional and a patient prior to the provision of a telehealth service;
    - Requiring patients or providers to demonstrate or document a hardship or access barrier to an in-person consultation;
    - Requiring telehealth services when a provider has determined it not appropriate or when a patient chooses an in-person
    - Creating originating or distance site restrictions;
    - Requiring patients to use a separate panel of health care professionals or facilities for telehealth services;

- Imposing deductibles, copayments/co-insurance, or other cost-sharing that exceed those required for in-person services.

Medicaid Provisions

- The Department of Healthcare and Family Services (HFS) has committed to the continuation of existing Medicaid telehealth coverage and reimbursement requirements, which provide for coverage and payment parity, after the COVID-19 public health emergency ends. HFS also committed to meeting with stakeholders to consider whether any Medicaid coverage or reimbursement provisions should be codified in state statute.

Other legislation of note:

The Improving Health Care for Pregnant and Postpartum Individuals Act (SB 967) which adopts recommendations included in the 2018 IDPH Maternal Morbidity and Mortality Report and includes provisions to require Medicaid and insurance plans cover various services associated with reducing the rate of maternal mortality. SB 967 passed both Chambers.

The Sexual Assault Nurse Examiners training requirement extension (HB 1739 SA5): delays a mandate that all treatment hospitals have a Qualified Medical Provider available to provide a medical forensic exam within 90 minutes of patient arrival, from January 1, 2022 to January 1, 2023. Also reinstates the provision for an adult survivor to be transferred to the closest treatment hospital, regardless of whether that hospital also treats pediatric patients. HB 1739 passed both Chambers.

Budget Bill (SB 2800) contains the following provisions impacting hospitals:

- $180 M ARPA funds to HFS for Illinois hospitals, guidance on distribution is forthcoming.
  - $30 M for safety nets
  - $150 M non-safety nets
- Appropriation for inpatient psychiatric per diem rate increase to $630 for safety net hospitals that was included in healthcare pillar
- $50 M appropriation for safety net perinatal services that was included in the health care pillar
- $150 M for second year funding of Hospital Transformation
- $200 million in hospital transformation capital (reappropriated)

Budget Implementation Bill (SB 2017)

- Repeals the 2012 SMART Act 3.5% Medicaid rate cuts, effective July 1, 2021

Omnibus Medicaid Bill (SB 2294)

- Ensures that patients, whether enrolled under the Medical Assistance Fee for Service program or enrolled with a Medicaid Managed Care Organization, experiencing opioid-related overdose or withdrawal are admitted on an inpatient status and the provider shall be reimbursed accordingly;
- Provides for inpatient reimbursement for long acting injectable medication for mental health and substance use disorders;
- Codifies HFS process and timeline for PACE Program

Ongoing priorities: AMITA Advocacy will continue to focus on legislative priorities that were not accomplished this session, including, Nurse Compact Licensure, 340b protections and holding MCO's accountable.