



Illinois Health and Hospital Association

IL AAHAM 2022 IHA Legislative and Regulatory Update

December 9, 2022

Today's Roadmap

- Recapping 2022
- 2023 Advocacy Agendas
 - State and Local
 - Federal
- Federal Regulatory Update
- Other Key State Issues
- Questions

Acronyms

- ASP – Average Sales Price
- CMS – Centers for Medicare & Medicaid Services
- CON – Certificate of Need
- CY – Calendar Year
- DSH – Disproportionate Share Hospital
- ED – Emergency Department
- FTE – Full Time Equivalent
- FY – Fiscal Year
- GME – Graduate Medical Education
- HAC – Hospital-Acquired Condition Program
- HEAL – Hospital Equity and Access Leadership
- HFSRB – Health Facilities & Services Review Board
- HHS – U.S. Department of Health and Human Services
- IDR – Independent Dispute Resolution
- IME – Indirect Medical Education
- IPPS – Inpatient Prospective Payment System
- MA – Medicare Advantage
- MCO – Managed Care Organization
- NSA – No Surprises Act
- OB – Obstetrics
- OON – Out-of-Network
- OPSS – Outpatient Prospective Payment System
- PAYGO – Pay-As-You-Go
- PILOT – Payment in Lieu of Taxes
- PN – Pneumonia
- REH – Rural Emergency Hospital
- RRP – Readmissions Reduction Program
- SCH – Sole Community Hospital
- SCOTUS – Supreme Court of the United States
- VBP – Value-Based Purchasing Program

Recapping 2022



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Slow Return to a New Normal

While the world sought normalcy, IHA continued to advocate on behalf of hospitals as COVID-19 and other healthcare issues remained top of mind:

Federal

- Secure additional financial and administrative relief for Illinois hospitals
- Engage with CMS and other agencies on Medicare payment and surprise billing requirements

State

- Coordination for continued pandemic regulatory flexibilities
- Shortened but packed legislative session
- Assessed how a post-Dobbs world impacts Illinois hospitals

State Level

IHA's Key State Legislative Issues from this Spring

- Reauthorization of the \$3.8B Assessment Program
- Additional funding successes for hospitals:
 - Hospital pandemic relief - \$240M
 - Extends the Investor-owned Tax Credit
 - Ends Sunset of Non-profit Hospitals Sales Tax Exemption
 - Prenatal/Postpartum Medicaid Rate Increases
 - Continuous Medicaid Eligibility
- Expanded rural provider financial assistance
- Addressed predatory nurse staffing agency practices

Veto Session/Lame Duck

Advocacy Efforts Continued into the Fall Veto Session

- Passage of Rural Emergency Hospital designation
- Important Trailer to Nurse Staffing Agency legislation
- Delayed fines for hospitals unable to meet Sexual Assault Nurse Examiner requirements until Jan. 2024

Federal Level

End-of-Year Legislative Priorities

- Prevent 4% PAYGO cuts
- Ease workforce shortages
- Extend critical programs and flexibilities
- Provide targeted fiscal relief via temporary per diem for patient boarding
- Streamline prior authorization process under MA plans



END-OF-YEAR LEGISLATIVE PRIORITIES

Illinois hospitals and health systems are facing unprecedented challenges and pressures, including severe staffing shortages, supply chain breakdowns, and record inflation for drugs, supplies and equipment. Congress' generous support for providers during the COVID-19 public health emergency (PHE) has not blunted the full impact of the immense expense and revenue pressures hospitals continue to face. A recent American Hospital Association (AHA) report by Kaufman Hall projects that margins will be down 37% the remainder of the year relative to pre-pandemic levels.

Hospitals cannot simply increase their prices to offset rising costs and reductions in revenues. The majority of inpatient utilization in Illinois hospitals involves Medicare and Medicaid, which provide fixed payments and reimburse less than the cost of providing care. According to a recent projection by MedPAC, hospital and health system margins on Medicare services will fall to -9% in 2022.¹ In Illinois, 94% of hospitals have 50% or more inpatient days paid by Medicare or Medicaid.²

To ensure Illinois hospitals can continue to provide essential care to patients and communities, IHA requests Congress take the following actions:

PREVENT 4% PAYGO CUTS TO HOSPITALS

Absent Congressional action, hospitals face a 4% cut to their Medicare payments in 2023, risking further destabilization to our already strained healthcare system. Largely due to the impact of the American Rescue Plan Act of 2021, PAYGO cuts are scheduled to take effect in 2023.


SUPPORT THE HEALTHCARE WORKFORCE

Invest in the healthcare workforce pipeline

- Pass the **Resident Physician Shortage Reduction Act (S. 834/H.R. 2256)** to raise the number of Medicare supported graduate medical education (GME) positions by 14,000 over seven years. IHA also supports the **Opioid Workforce Act/Substance Use Disorder Workforce Act (S. 1438/H.R. 3441)**, introduced by Rep. Brad Schneider (IL-10), which would add 1,000 positions in addiction medicine or pain management. Additionally, IHA supports draft legislation from the Senate Finance Committee that would add 400 new GME slots for psychiatry and psychiatry subspecialties.

Rural Emergency Hospitals

- REH services = OPPS services
- Payment: OPPS + 5%
- Monthly facility payment
- Other services paid under relevant Medicare fee schedule
 - Some required, others optional
- REH quality program still under development
- Physician self-referral law rural provider exception
- Used OPPS final rule to finalized REH Conditions of Participation



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MEDICARE PAYMENT FACT SHEET

NOVEMBER 2022

RURAL EMERGENCY HOSPITALS

On Nov. 3, the Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2023 outpatient prospective payment system (OPPS) [final rule](#). Within this rule, CMS finalized policies and procedures specific to rural emergency hospitals (REHs), including CMS-3419-F which finalizes Conditions of Participation (CoPs) for REHs. This fact sheet summarizes the REH portion of the CY 2023 OPSS final rule. For a summary of CMS-3419-F, see IHA's Rural Emergency Hospital – CoPs [fact sheet](#).

Definition REH Services: "REH services" are all services paid under the OPSS when furnished in an OPSS hospital as defined by the Social Security Act (SSA), section 1833(t)(1)(B) with the exception of services described in section 1833(t)(1)(B)(ii) (i.e. inpatient hospital services).

Payment for REH Services: CMS finalized the following payment policies for REH services:

- The payment rate for an REH service will be the OPSS rate for the equivalent covered outpatient department service increased by 5%;
- REH claims will be processed within the OPSS claims processing system. This system will be updated to include an REH-specific payment flag, resulting in the REH-specific payment rate stated above; and
- Beneficiary copayments for REH services will reflect the copayment amounts determined under the OPSS for the equivalent covered outpatient department services. REH copayments will exclude the 5% payment increase that applies to the REH service payment.
- The CY 2023 monthly REH facility payment will be \$272,866. This is higher than the amount stated in the proposed rule due to a calculation error. This payment amount will increase by the hospital market basket in future years.

Other Outpatient Services: REHs must provide other types of outpatient services that are not paid under OPSS. These include basic lab services and certain diagnostic services as specified under the REH CoPs.

REHs may also provide outpatient and medical health diagnostic and therapeutic items and services including but not limited to radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health services.

Outpatient services that do not meet the definition of REH services will be paid at the same rate the service would be paid if performed in a hospital outpatient department, provided that the requirements for the relevant payment system are met.

Packaging of Laboratory Services: If a lab service would be packaged into an OPSS payment for a primary service or services furnished by a hospital that is paid under OPSS, then it will be packaged into the REH payment for the analogous primary service or services when furnished by

Preparing for 2023



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2023 Federal Advocacy Priorities

Stability

- Financial Stability
- Payer Accountability
- Rural & Underserved

Resiliency

- Workforce
- Equity
- Behavioral Health

Transformation

- Virtual Care
- Value
- Preparedness

2023 Federal Advocacy Agenda



IHA will **advocate** for policies that promote:

Stability

Resiliency

Transformation

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2023 State Advocacy Agenda

Key Issues IHA will be Addressing at the State Level

Hospital Funding

- Adequate state funding through Medicaid
- Safety Net Hospital Equity and Access Leadership (HEAL)

Workforce

- Nurse Licensure Compact
- Nurse Staffing Ratios
- Violence in Healthcare Facilities
- Processing of Healthcare Professional Licenses
- Workforce Funding

2023 State Advocacy Agenda, *continued...*

MCO/Commercial Payer Practices

Authorization Practices

- Operational standardization across MCO utilization management programs

White and Brown Bagging

- Oppose unnecessary restrictions on patient access to covered benefits/medications that have detrimental effects

“Bait & Switch” Practices

- Antics by payers to restrict access to covered benefits, often in middle of the plan year and with little notice
 - “Site-of-Care” policies
- Advocate for focus on value-based initiatives, not just cost savings

Federal Regulatory Update



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No Surprises Act

Still being challenged, modified and implemented:

- February: federal judge vacates certain IDR requirements
- April: IDR portal opens
 - Significant backlog
- June: Governor signed Public Act 102-0901/HB 4703
 - Amends Illinois' surprise billing law to better align with the NSA
 - State arbiters may not assume median in-network rate is appropriate reimbursement for OON providers
- August: new final rules implementing IDR
 - Updated disclosure requirements for health plans
 - Restated IDR requirements for determining appropriate OON payment
 - New “double-counting” rule
 - IDR written explanation requirements
- November: IHA submits comments on advanced explanation of benefit and insured good faith estimate requirements

NSA Resources


CMS

- www.cms.gov/nosurprises
- Send questions to: FederalIDRQuestions@cms.hhs.gov
- No Surprises Help Desk at 1-800-985-3059



Ending Surprise Medical Bills

See how new rules help protect people from surprise medical bills and remove consumers from payment disputes between a provider or health care facility and their health plan



Learn More

Policies & resources

Review rules and fact sheets on what No Surprises rules cover, and get additional resources with more information.

- Overview of rules & fact sheets
- Provider resources
- Providers: submit a billing complaint
- Providers: payment resolution with patients
- Plans and Issuers resources
- Privacy policies & notices for this website

Resolving out-of-network payment disputes

Learn about out-of-network payment disputes between providers and health plans and how to start the independent dispute resolution (IDR) process, apply to become a certified independent dispute resolution entity, or submit a petition on an applicant or to revoke certification of a current IDR entity.

- Learn about or start a payment dispute
- Tips for disputing parties
- Become a dispute resolution organization
- List of certified organizations
- Submit petition to deny IDR certification
- Submit petition to revoke IDR certification

Consumers

Learn about rights and protections for consumers to end surprise bills and remove consumers from payment disagreements between their providers, health care facilities and health plans.

For consumers: your rights, protections & resources

IHA


- IHA Price Transparency website
- Send questions to: cyarbrough@team-iha.org

PATIENT NOTICES AND DISCLOSURES EFFECTIVE JAN. 1, 2022		No Surprises Act		
Public Disclosure of Rights Related to Balance Billing	Patient Disclosure of Rights Related to Balance Billing	Rights Related to Good Faith Estimates	Good Faith Estimates - Uninsured/Out-of-Pay Patients	Notice and Consent to Balance Bill
Insured patients in a group health plan or group/individual health insurance coverage offered by health insurance issuer, including the Federal Employees Health Benefits Program	Insured patients in a group health plan or group/individual health insurance coverage offered by health insurance issuer, including the Federal Employees Health Benefits Program	Uninsured/Out-of-Pay Patients	Uninsured/Out-of-Pay Patients	Insured patients in a group health plan or group/individual health insurance coverage offered by a health insurance issuer, including the Federal Employees Health Benefits Program
Facilities/providers must make publicly available information on patients' rights regarding balance billing, including state specific rights under 6.2005, 6.2020, 6.2122. Facilities/providers may use CMS model form (LMS-6100) Appendix A, which is referred to reflect 28.096.1122	Facilities/providers must give each insured patient a copy upon request of their rights under the No Surprises Act and a Patient AS 096.1122. Facilities/providers may use CMS model form (LMS-6100) Appendix A, which is referred to reflect 28.096.1122	Facilities/providers must notify uninsured/out-of-pay patients both orally and in writing of their right to receive a good faith estimate of expected costs. Facilities/providers may use CMS model form (LMS-6100) Appendix A, or create a private form that includes the same information for health contracting and co-providers.	Facilities/providers must provide a good faith estimate of expected charges both orally and in writing. Facilities/providers may use CMS model form (LMS-6100) Appendix A, or create a private form that includes the same information for health contracting and co-providers.	In certain limited circumstances, out-of-network facilities and providers may seek an insured patient's consent to balance bill. Facilities/providers may use CMS model form (LMS-6100) Appendix B, which is referred to reflect the specific insured patient.
The public notice must be a searchable homepage of the facility/provider website. Facilities/providers must also prominently display in sign with the required disclosure information in a location of the facility/provider, such as where individuals schedule care, check-in for appointments, or pay bills, unless the provider does not have a publicly accessible location.	Facilities/providers must provide the notice in-person, by mail, or by email, as selected by the insured patient.	Information regarding the availability of a good form estimate must be prominently displayed on the curbside, facility's/provider's website and in the office and on-site where scheduling or questions about the cost of health care occur.	When the uninsured/out-of-pay patient schedules an appointment or upon request. For items/services scheduled 30 or more days in advance, providers have 3 business days to furnish a good faith estimate. For items/services scheduled 30 or more days in advance, providers have 3 business days to furnish a good faith estimate.	For items/services at least 72 hours out, provide the notice and consent at least 72 hours before the appointment. For items/services scheduled within 72 hours, provide the notice and consent on the day the appointment is scheduled. For same day items/services, provide the notice and consent no later than 3 hours prior to the appointment.

For more information and a complete list of requirements, see IHA's summary of [Aggregate Billing Policies Effective Jan. 1, 2022](#), the [No Surprises Act Implementation Guidelines](#), and IHA's [No Surprises Act Toolkit](#) (download to Your Transparency) and [IHA Documents](#).


FY 2023 IPPS Update

- Estimated payment increase of 2.9% (\$142.7M) across IL hospitals
- DSH: will average 3 years of S-10 data to determine hospital payments
- IME/GME Changes
 - Adjust weighted FTE count when it exceeds FTE cap
 - Rural Track Medicare GME Affiliation Agreement
- Reclassified hospitals included in wage index rural floor
- Continued measure suppression across quality programs
 - No HAC, VBP penalties this year
 - RRP PN measure suppressed

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AUGUST 2022				
FY 2023 MEDICARE IPPS PROPOSED RULE (CMS-1771-F) On Aug. 1, the Centers for Medicare & Medicaid Services (CMS) posted the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) final rule, effective Oct. 1, 2022 through Sept. 30, 2023. CMS finalized a 4.3% rate increase relative to FY 2022.				
IPPS Rate Update: CMS finalized a 4.1% market basket update, a 0.3 percentage point Affordable Care Act-mandated productivity reduction, and a 0.5 percentage point increase to partially restore cuts made under the American Taxpayer Relief Act (ATRA) of 2012. The initial market basket update for hospitals that fail to submit quality data will decrease by an additional one-quarter, and hospitals that do not meet meaningful use requirements are subject to a three-quarter initial market basket reduction.				
	Submitted quality data and is a Meaningful EHR user	Submitted quality data and is NOT a Meaningful EHR user	DID NOT submit quality data and is a Meaningful EHR user	DID NOT submit quality data and is NOT a Meaningful EHR user
Percentage increase applied to standardized amount	4.30%	1.23%	3.28%	0.20%
CMS used the most recent year of complete data available in calculating rates. For FY 2023, this includes using FY 2021 MedPAR claims and FY 2020 cost report data. To account for the impact of COVID-19, CMS finalized several modifications to its calculation of Medicare Severity Diagnosis Related Group (MS-DRG) relative weights.				
CMS also finalized a decrease for outlier payments, resulting in a 1.7 percentage point decrease to the rate update. The finalized fixed-loss amount is \$38,859, which is substantially lower than the proposed threshold of \$43,214.				
The table below summarizes finalized FY 2023 standardized amounts. CMS finalized a labor-related share of 67.6% for IPPS hospitals with wage index values greater than 1.0000, and a labor-related share of 62% for IPPS hospitals with wage index values less than or equal to 1.0000.				
Wage Index	Submitted Quality Data and is a Meaningful EHR User	Submitted Quality Data and is NOT a Meaningful EHR User	DID NOT Submit Quality Data and is a Meaningful EHR User	DID NOT Submit Quality Data and is NOT a Meaningful EHR User
> 1.0000	Labor: \$4,310.00 Non-Labor: \$2,065.74	Labor: \$4,182.32 Non-Labor: \$2,004.54	Labor: \$4,267.44 Non-Labor: \$2,045.34	Labor: \$4,139.76 Non-Labor: \$1,984.15
<= 1.0000	Labor: \$3,952.96 Non-Labor: \$2,422.78	Labor: \$3,835.85 Non-Labor: \$2,351.01	Labor: \$3,913.92 Non-Labor: \$2,398.86	Labor: \$3,796.82 Non-Labor: \$2,327.09

CY 2023 OPPS Update

- Estimated payment increase of 3.7% (\$108.6 M) across IL hospitals
- Extends remote mental health services
- Extends telehealth flexibilities
 - Certain cardiac rehab services
- Adds facet joint intervention services to prior authorization requirements
- Rural SCH clinic visits paid at OPPS rate



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MEDICARE PAYMENT FACT SHEET

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CY 2023 MEDICARE OPPS FINAL RULE – CMS-1772-F

On Nov. 3, the Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2023 outpatient prospective payment system (OPPS) [final rule](#). Overall, CMS finalized a rate update of 3.8% relative to CY 2022, estimating an increase of \$6.5 billion compared to CY 2022 OPPS payments.

Within this rule, CMS finalized policies and procedures specific to rural emergency hospitals (REHs), including CMS-3419-F, which finalizes Conditions of Participation (CoPs) for REHs. An IHA summary of finalized REH payment policies and procedures is [here](#). An IHA summary of finalized REH CoPs is [here](#).

CMS also restored reimbursement for 340B-acquired drugs and biologicals to average sales price plus 6% for CY 2023. An IHA memo summarizing CMS' CY 2023 340B payment policy is [here](#).

OPPS Rate Update: CMS finalized a 4.1% market basket update and a 0.3 percentage point productivity reduction for OPPS payments, resulting in a 3.8% update to OPPS rates for hospitals that meet quality data submission requirements. After accounting for all adjustments, CMS finalized a CY 2023 conversion factor of \$85.585. Hospitals that fail to submit quality data will be subject to a 2-percentage point reduction to payments, resulting in a conversion factor of \$83.934. CMS used CY 2021 claims data and cost report data from the June 2020 Healthcare Cost Report Information System (HCRIS) extract for CY 2023 rate-setting purposes.

Remote Mental Health Services: CMS will cover remote mental health services furnished via telehealth by hospital staff to beneficiaries in their homes under the OPSS. CMS created OPSS-specific coding for these services, which are listed and described in [Table 66](#) of the final rule. Final CY 2023 payment rates for these services are listed in [Table 67](#) and align with the Medicare Physician Fee Schedule (PFS).

CMS requires an in-person visit within six months prior to the initiation of remote services, and then every 12 months thereafter. CMS will grant exceptions to the in-person visit requirement based on beneficiary circumstances. The requirement to have an in-person visit six months prior to the start of remote services applies to patients beginning telehealth mental health services on or after the 152nd day after the end of the public health emergency (PHE).

CMS will allow audio-only telehealth in instances where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology.

Direct Supervision of Certain Cardiac and Pulmonary Rehabilitation Services: CMS revised the definition of direct supervision for pulmonary, cardiac, and intensive cardiac rehabilitation services. Until Dec. 31, 2023, such services now include the presence of the supervising practitioner through two-way, audio/video telehealth when the beneficiary is physically located in the hospital. This mirrors a finalized policy under the CY 2023 Medicare PFS final rule that allows beneficiaries living in rural areas to continue receiving these rehabilitation services

340B

- June: unanimous SCOTUS decision found HHS inappropriately lowered 340B reimbursement to ASP - 22.5%
 - HHS must first survey hospitals for acquisition costs
- OPPS final rule restores reimbursement to ASP + 6% for 2023
 - Budget neutral, resulting in lower 2023 OPPS conversion factor
- September: federal judge vacated ASP - 22.5% for remainder of CY 2022, starting Sept. 28
- CMS still evaluating remedy for claims with 2018 through 2022 dates of service

Other Key State Issues



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Substantive State Policy Issues

Certificate of Need

- Under significant scrutiny:
 - Hospital Closures/Changes of Ownership
 - Ending categories of service (OB, pediatrics, etc.)
 - Suspending or flexing services during the pandemic
- Expect efforts in 2023 to curtail hospital abilities under CON

Small Format Hospitals

- Unexpected approval of small format hospital in Quincy in May
- Lacks clear regulations in Illinois
- Working with HFSRB on appropriate guidelines for these facilities

Substantive State Policy Issues, *continued...*

Access to Reproductive Services

- Dobbs decision created a flurry of reproductive health activity
- Border states restrict - Illinois seeks to expand access/protection
- Significant jump in out of state women seeking abortions
- Actively monitoring and engaged with stakeholders on this issue

Women's Health

- High mortality/morbidity rates for pregnant and postpartum women - particularly among minority populations
- Hospitals continue to end OB & pediatric services
- Maternal and Perinatal Levels of Care likely to come in 2023

Substantive State Policy Issues, *continued...*

Nonprofit Hospital Property Tax Exemption

- Continued litigation over the legality of the exemption
- Attempts by municipalities to get money from nonprofit entities like hospitals - PILOTs

Public Option

- IHA has and continues to support greater access to healthcare
- Strengthen the Health Insurance Exchange while preserving/enhancing a robust commercial marketplace
- Invest in enrollment activities for the uninsured
- Oppose a Basic Health Plan or other plans that will shift individuals off their current insurance

Substantive State Policy Issues, *continued...*

Healthcare Transformation Funding

- \$150M per year to fund collaborative efforts to reduce health disparities, advance health equity, and improve health in vulnerable communities
- Aligns with IHA's vision for healthcare transformation
- Support continued funding focusing on collaborative efforts

Medical Malpractice

- Issue continues to be a top focus for IHA
- High rates are unsustainable - challenging healthcare reform
- Considering the landscape, a multi-year approach is necessary to address this issue

Substantive State Policy Issues, *continued...*

Boarding of Behavioral Health Patients

- COVID-19 has taxed resources and increased pre-pandemic challenges in patient transfer and discharge
- Mental health services cannot be provided in ED, medical, or surgical units unless admitted
- Complex issues involving multiple agencies/stakeholders
- Seek opportunities for reimbursement, agency interoperability, and reduce barriers to placing youth populations

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