AHPA
ADVENTIST HEALTH POLICY ASSOCIATION

H.R. 133: Provisions Impacting Health Systems

On December 21, 2020, Congress passed the "Consolidated Appropriations Act of 2021," which includes funds to address the COVID-19 pandemic in addition to critical health care provisions impacting health providers. Many of the legislation's provisions will require the Department of Health and Human Services (HHS) to issue rules prior to implementation and more details will be finalized through those rules. Below are those health care provisions unrelated to COVID-19 that will impact health care systems. To view the legislative text, click here.

Issue	Overview	Key Details
Surprise Billing	Beginning on January 1, 2022, protects patients from surprise medical bills, including air ambulance bills, while also creating an Independent Dispute Resolution (IDR) process for health providers and insurers to dispute out-of-network claims. Unlike previous bills, the legislation does *not* include any benchmarking or rate-setting.	**Surprise Billing Protections** (page 4095) • Protects patients from surprise medical bills arising from out-of-network emergency care (including air ambulance), ancillary services provided by out-of-network providers at in-network facilities, and out-of-network services provided at in-network facilities without the patient's informed consent. • Prohibits health providers from balance billing patients beyond the in-network cost-sharing amount, which will be determined through a formula established by the HHS Secretary. • Requires health providers to post on the facility's public website, a one-page notice outlining the balance billing protections of the legislation, along with any other relevant state law requirements. Providers must also share the notice with individuals who are "participants, beneficiaries, or enrollees of a group health plan" electronically or by mail as specified by the individual. (page 4297) **Independent Dispute Resolution Process** (page 4208) • Directs the Secretaries of HHS, Labor and Treasury to establish an IDR process through future rulemaking. • Provides a 30-day open negotiation period for providers and insurers to settle out-of-network claims. If the parties are unable to reach an agreement, they can engage in the IDR. ○ The 30-day period begins on the day the provider receives an initial payment or a notice of payment denial. • IDR is initiated when the provider or plan submits a notification to the other party and Secretary of HHS. • The IDR will be administered by an independent, private entity and there will be no dollar threshold for claims to qualify. • Providers may batch similar services or those that are part of a bundled payment in one proceeding when claims are from the same payer.

		• Payments must be made within 30 days of the date on which an IDR determination is made. • To determine the reimbursement rate, the arbitrator is required to consider the market-based median in-network rate, alongside other factors, such as patient acuity and the complexity of services. • The party whose offer was not chosen by the IDR entity, pays the costs of the IDR. • Parties that use the IDR process will be required to pay an administrative fee to the Secretary each year. The amount to be established by the Secretary of HHS. **Applicability** • For those states with existing balance billing measures, the reimbursement and IDR provisions of this legislation will apply only to health plans regulated by the federal government, such as Employee Retirement Income Security Act of 1974 (ERISA) plans.
Transparency	Establishes transparency requirements for both health providers and health insurers. This includes requiring providers to inform patients of their out-of-network status and providing an estimate of charges at least 72 hours before furnishing a scheduled service. Providers will also be required to obtain a patient's written consent and preserve that documentation for at least seven years. The provisions on this section will take effect beginning on January 1, 2022.	**Price Estimates** Health Provider Requirements (page 4400) • Beginning on January 1, 2022, requires providers to inform patients of their network status and provide a "good faith estimate" of charges at least 72 hours before furnishing a scheduled service. These estimates must be provided also for any ancillary services, along with the expected billing and diagnostic codes. o For appointments made within 72 hours of receiving an out-of-network service, the notice must be provided to the patient on the day the appointment is made. If the service is in-network, the provider must share the good faith estimate no later than one day after scheduling the service. • Requires HHS to establish a patient-provider dispute resolution process for uninsured individuals by no later than January 1, 2022. The process would allow uninsured patients to dispute claims that are "substantially in excess" of the good faith estimate. This term may be defined through rulemaking. • For out-of-network services, requires providers to obtain the patient's written consent prior to furnishing the service and retain that documentation for at least seven years after the service is provided. Insurer Requirements (page 4387) • Requires insurers to provide patients with an Advance Explanation of Benefits (EOB) when a provider notifies the insurer or group health plan that an enrollee is scheduled to receive a health care service. o The EOB must include, among other things, whether or not a provider is in-network, the contracted rate for the service or item, the good faith estimate received from the health provider, a good faith estimate from the insurer of

		the amount the plan is responsible for paying and a good faith estimate of the patient's cost-sharing. o The EOB must be provided no later than one business day after a health provider notifies the insurer of the scheduled service or after three business days if the notification is done by the enrollee. **Price Comparison Tool and Provider Directory Information** (page 4420) • Requires health plans to develop and maintain a price comparison tool that will allow enrollees to compare the amount of cost-sharing that the individual would be responsible for paying under such plan for a specific item or service by the plan's in-network providers. • Requires health plans to maintain an up-to-date directory and database of their in-network providers, to be available to patients online or within one business day of an inquiry. If a patient provides documentation that they received incorrect information from a plan about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount. **Transparency Regarding In-Network and Out-of-Network Deductibles** (page 4378) • Requires insurers to include in enrollees' insurance identification cards, the amount of their in-network and out-of-network deductibles and the out-of-pocket maximum limitations. • Identification cards must also include a telephone number and website for consumer assistance. **Gag Clauses on Price and Quality Information** (page 4465) • Prohibits the use of contractual language between health plans and providers that prevent health plan sponsors, group and individual market consumers from accessing provider-specific cost and quality of care information. • Requires group health plans or a health insurance issuer offering group or individual health insurance coverage, to annually submit to HHS an attestation of compliance with this gag clause prohibition. **Brokers and Consultants** (page 4475) • Requires brokers and consultants to disclose any direct or indirect compensation they receive from employer-sponsored health plans for referral services. This information must be disclosed to plan sponsors, enrollees in the individual market or enrollees purchasing short-term limited duration insurance. **Air Ambulances**

		• Requires air ambulance providers to submit two years of cost data to the Secretaries of HHS and Transportation. • Requires insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS, beginning no later than 90 days after the last day of the first calendar year on or after the date on which a final rule is issued. • Establishes an advisory committee on air ambulance quality and patient safety within 60 days of the law's enactment. **State All-Payer Claims Database** (page 4423) • Directs HHS to make one-time grants to states for the purpose of establishing or improving all-payer claims databases. • Grants should be in the amount of $2.5 million, of which $1 million must be made available to the state for the first two years of the grant period and $500,000 for the third year.
Physician Fee Schedule (PFS)	Includes a partial fix to the provider reimbursement cuts finalized in the PFS CY 2021 final rule.	• Imposes a moratorium until January 2024 for CPT code G2211, the visit add-on code that increased payments for office-based practitioners seeing more complex patients. This is estimated to mitigate the payment reductions by one third. This means that the code will not be reimbursable until January 2024. (page 4620) • Provides an additional $3 billion to the PFS, which will increase PFS payments across the board by 3.75% in CY 2021.
Provider Relief Fund (PRF)	Makes changes to the PRF in response to concerns shared by health providers regarding how to calculate lost revenues and distribute PRF funds.	• Appropriates an additional $3 billion for the PRF. • Allows providers to calculate lost revenues using the Frequently Asked Questions guidance released by HHS in June 2020, which specified that providers can use "any reasonable method" for the calculation. This includes the difference between budgeted and actual revenue if such budget had been established and approved prior to March 27, 2020. (page 1851) • Clarifies that health systems may move all PRF distributions within their system. (page 1851)
Continuity of Care	Protects patients with complex care needs from being charged higher, out-of-network costs, in situations when the patient's health provider changes network status. The goal of this policy is to provide sufficient time for a patient to find an in-network health provider.	• If a health provider changes network status, requires insurers to give patients with complex care needs a 90-day period of continued coverage paying the in-network cost-sharing. (page 4404)

Mental Health	Seeks to increase access to mental health by ensuring that health insurers are complying with mental health parity laws and by providing Medicare coverage of mental health services provided through telehealth, regardless of the location.	**Mental Health Parity** (page 4491) • Requires insurers and group health plans to analyze their compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and make those analyses available upon HHS' request. • If the Secretary of HHS finds an insurer to be out of compliance, the insurer will have up to 45 days to demonstrate compliance. **Telehealth Coverage** (page 4644) • Provides Medicare coverage for mental health services furnished through telehealth regardless of the location, including from the patient's home. • To be eligible, the patient must have received an in-person service at least once with their physician or nonphysician practitioner during the six-months prior to the first telehealth service and during a subsequent period to be determined by HHS in the future. • The legislation gives HHS the flexibility to implement this provision through an interim final rule, program instruction, or otherwise.

Post-Acute Care	Seeks to improve the quality of care provided in the post-acute care setting by instituting policies such as the increase of measures included in the Skilled Nursing Facility VBP program and instructing MedPAC to provide a report on the development of a VBP program that would run across all post-acute care providers under a unified payment system.	**MedPAC Report for Unified Post-Acute Care System** (page 4616)
		• Directs the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress by March 15, 2022, on establishing a prototype value-based payment program under a unified prospective payment system for post-acute care services. This report would inform future policymaking.
		
		Skilled Nursing Facility Value-Based Purchasing Program (VBP) (page 4612)
		• Allows the HHS Secretary to add no more than 10 quality measures to the Skilled Nursing Facility Value-Based Purchasing Program, which may include measures of functional status, patient safety, care coordination or patient experience.
		
		Home Health
		• Requires HHS by January 1, 2022, to allow occupational therapists to conduct initial assessment visits for home health services if the patient's health plan (page 4623):
		  ○ Does *not* initially include skilled nursing care;
		  ○ Includes occupational therapy; and
		  ○ Includes physical therapy or speech language pathology.
		• Provides for continued coverage of home infusion therapy services for Medicare patients taking self-administered and biological drugs that are currently included under the temporary transitional home infusion therapy benefit when the permanent home infusion therapy benefit takes effect January 1, 2021. (page 4626)

Graduate Medical Education	Increases the number of Medicare-funded Graduate Medical Education (GME) positions.	**Additional Residency Positions** (page 4674) • Beginning Fiscal Year (FY) 2023, provides for the distribution of additional Medicare-funded GME residency positions. There will be a total of 1,000 new positions with only up to 200 to be made available every fiscal year. ○ Rural hospitals, hospitals already above their Medicare cap for residency positions, hospitals in states with new medical schools and hospitals that serve Health Professional Shortage Areas (HPSAs) will be eligible for these new positions. **GME Rotations** (page 4694) • Allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full-time equivalent (FTE) resident cap or a Per Resident Amount (PRA).
CMMI Models	Delays the implementation of the Radiation Oncology model by six months and temporarily freezes the current payment and patient count thresholds for physicians participating in Advanced Alternative Payment Models (APMs) for payment years 2023 and 2024.	**Radiation Oncology Model** (page 4702) • Delays implementation of the Radiation Oncology model to January 1, 2022. **APM Payment Incentive Thresholds** (page 4621) • For physicians participating in APMs, freezes the current payment and patient count thresholds for payment years 2023 and 2024 (covering performance years 2021 and 2022). • Freezes the Partial Qualifying APM payment threshold and patient count threshold at current levels for payment years 2023 and 2024 (covering performance years 2021 and 2022).
Rural Health	Creates a new Medicare designation for Rural Emergency Hospitals (REH) and increases the statutory cap for Rural Health Clinics (RHCs).	**New Rural Designation** (page 4655) • Creates a new, voluntary Medicare payment designation that allows either a Critical Access Hospital (CAH) or a rural hospital with less than 50 beds to convert to an REH. ○ REHs will be reimbursed under all applicable Medicare prospective payment systems and receive an additional monthly facility payment and an add-on payment for hospital outpatient services. • Allows REHs to furnish additional medical services needed in their community such as observation care, outpatient hospital services, telehealth services, ambulance services and SNF services. • Directs HHS to establish quality measurement reporting requirements for REHs, which may include the use of a small number of claims-based outcomes measures or surveys of patients.

		Rural Health Clinics' Payments (page 4691) • Implements a payment reform plan for RHCs. Phases in an increase in the RHC statutory cap over an eight-year period, subjects all new RHCs to a uniform per-visit cap, and controls the annual rate of growth for uncapped RHCs whose payments are above the upper limit. • RHCs with an all-inclusive rate above the upper limit would continue to experience annual growth but the payment amount would be constrained to the facility's prior year reimbursement rate plus Medicare Economic Index (MEI). • Raises the statutory RHC cap to $100 starting on April 1, 2021, and gradually increases the upper limit each year through 2028 until the cap reaches $190 per visit. In each subsequent calendar year, starting in 2029, the new statutorily set RHC cap would revert back to an annual MEI inflationary adjustment.