

**H.R. 133**

***Select Health Care Provisions***

**Highlights**: This omnibus bill funds the federal government at $1.4 trillion through the end the current fiscal year (September 30, 2021) and includes COVID-19 relief and other health policy provisions totaling another $900 billion. Highlights include: an additional $3 billion in Provider Relief Funding (PRF) plus changes to the terms and conditions; a freeze on the MACRA Advanced APM thresholds; a prohibition on surprise billing; adjustments to several Medicare payment policies, including payments for physician services; provider and plan transparency related requirements; and an extension of expiring healthcare programs for three years.

**Missing in Action**: Some proposals were victims of the negotiations and have been removed or reduced in HR 133. The PRF amount was reduced from $35 billion, telehealth waiver authorities were not extended, additional state and local financial aid are absent, and FMAP was not increased.

**Provider Relief Fund –** *UPH and AHA advocacy positions*

* Additional $3 billion
* Use Clarified: building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity
* Health System Flexibility: parent organization may allocate (through transfers or otherwise) all or any portion of such reimbursement among its subsidiaries, including ‘‘Targeted Distribution’’ payments, except reporting duties remain with the original recipient
* Lost Revenues Calculation: may use HHS FAQ guidance (June 2020), including the difference between such provider’s budgeted and actual revenue budget if budget established and approved prior to March 27, 2020

**Coronavirus Relief Fund Extension –** *UPH advocacy position*

* Extends the date by which state and local governments must make expenditures with CARES Act Coronavirus Relief Fund awards from December 30, 2020 to December 31, 2021.

**Additional Medicare Provisions**

* Temporary Freeze on Advanced APM Thresholds – maintains both the current payment and patient count thresholds for payment years 2023 and 2024 (performance years 2021 and 2022) **-** *UPH advocacy position in conjunction with NGACO Coalition and NAACOs*
* Physician Fee Schedule – mitigates and phases-in negative payment adjustments (mainly to specialists) attributed to the E/M code increases. There is a $3 billion one-time, one-year increase of 3.75% in 2021 and a 3-year moratorium on the E/M add-on code for complexity. –*includes UPH advocacy position*
* Medicare Sequestration - 3-month delay of payment reductions through March 31, 2021 **–** *AHA and UPH advocacy position*
* Mental Health Services Via Telehealth – Reimburses for mental health services to certain existing patients through telehealth, including from the beneficiary’s home; *UPH advocacy position*
* Home Health Assessment Flexibility – Permits occupational therapists to conduct initial assessment visits and complete comprehensive assessments for certain home health services if the referral order by the physician does not include skilled nursing care but includes occupational therapy and physical therapy or speech language pathology
* Home Infusion Therapy Services Continuity – Ensures coverage for beneficiaries taking self-administered and biological drugs under the temporary transitional home infusion therapy benefit when the permanent home infusion therapy benefit takes effect January 1, 2021
* Hospice Benefit Billing by RHCs and FQHCs – Permits billing for hospice attending physician services when RHC and FQHC patients become terminally ill and elect the hospice benefit, beginning January 1, 2022.
* Hospice Cap Calculation - applies the hospice payment update percentage to the hospice aggregate cap for fiscal years 2026 through 2030.
* Hospice Program Survey and Enforcement – Conduct surveys no less frequently than once every 36 months.
* Delay CMMI Mandatory Radiation Oncology Model – Adds a 6-month delay to being first performance year on January 1, 2022; *impacts UPH regions* *of Peoria, IL and Waterloo, IA*
* Physician Assistant (PA) Reimbursement - Allows direct payment to PAs for services furnished to beneficiaries on or after January 1, 2022
* Oxygen Reimbursement – Waives budget neutrality and increases payment for new payment classes of oxygen and oxygen equipment.
* Coinsurance for Colorectal Cancer Screening Tests. Phases out cost-sharing for Medicare beneficiaries for screening tests where a polyp is detected and removed beginning January 1, 2022 through 2029.
* Rural Community Hospital Demonstration Extension – Extends this demonstration by 5 years; *UPH advocacy position;* *Grinnell Regional Medical Center and Trinity Regional Medical Center (Fort Dodge) are participants*
* Rural Emergency Hospital Demonstration – Creates new rural hospital designation to convert existing CAHs or small PPS hospitals. Services, aside from emergency medical care, may include observation care, outpatient hospital services, telehealth services, ambulance services, and skilled nursing facility services. Reimburse relies on PPS, with addition of monthly facility payment and 5% add-on for hospital outpatient services; *UPH involved with Grassley, AHA, IHA and Iowa health systems in crafting concept, although reimbursement methodology has been revised*
* Rural Health Clinic (RHC) Payment Reform – Phases-in a steady increase in the RHC statutory cap over an 8-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. Specifically, the policy 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.
* GME Rural Training Tracks (RTT) Reform – Provides greater flexibility for participation.

**Extenders -**

* Work geographic index floor under the Medicare program was extended through December 31, 2023; *UPH advocacy position*
* Medicaid DSH payment reduction was delayed, effectively postponing DSH reductions through FY 2023. DSH reductions are subsequently extended for two additional years, resulting in planned cuts of $8 billion per year in each year FY 2024 through FY 2027. *AHA and UPH advocated for delay*
* “Money Follows the Person” demonstration program is extended through federal fiscal year (FFY) 2023.
* Nonemergency medical transportation to necessary services must be covered under Medicaid.

**Funding – Potential Grant Opportunities and Passthrough Funds to Watch**

**Department of Health and Human Services, Public Health and Social Services Emergency Fund**

* $25.4 billion to support testing and contact tracing, including $2.5 billion for high-risk and underserved populations

**Assistant Secretary for Preparedness and Response -** $3.25 billion for the Strategic National Stockpile

**Centers for Disease Control and Prevention (CDC)**

* $8.75 billion to support federal, state, local, territorial and tribal public health agencies to distribute, administer, monitor, and track coronavirus vaccination, including $4.5 billion to public health departments and $300 million for distribute and administer vaccines to high-risk and underserved populations
* $201 million, an increase of $25 million, for influenza planning and response
* $695 million, an increase of $20 million, for public health emergency preparedness cooperative agreements with State and local health departments
* $361 million, an increase of $7.5 million, to strengthen epidemiologic and laboratory capacity, and includes $50 million to support modernization of public health data surveillance and analytics at CDC, State and local health departments
* $56 million, an increase of $5 million, for public health workforce and career development

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

* Mental health resources: including a new $35 million crisis care initiative within the Mental Health Block Grant; and expanded services and support for mental for children and youth including $107 million for Project AWARE, an increase of $5 million; and $72 million for the National Child Traumatic Stress Initiative, an increase of $3 million
* Suicide prevention: including $21 million for the Zero Suicide program, an increase of $5 million; and $24 million for the Suicide Lifeline, an increase of $5 million
* Substance abuse treatment: $3.8 billion, an increase of $17 million, including continued funding for opioid prevention and treatment
* Substance abuse prevention: $208 million, an increase of $2 million

**Health Resources and Services Administration (HRSA)**

* $1.2 billion, an increase of $30 million, for Bureau of Health Professions programs to support the medical workforce.
* $975 million, an increase of $32 million, for programs to improve maternal and child health.
* $286 million for the Title X Family Planning program.

**Broadband Access via different agencies**

* Federal Communications Commission (FCC): $250 million – COVID-19 Telehealth Program; *UPH had pending grant application when fund depleted*
* United States Department of Agriculture (USDA): $300 million – broadband deployment program targeting infrastructure in rural areas; *listed in UPH legislative agenda*

**Surprise Billing - “No Surprises Act”**

* Prohibits surprise billing by providers and facilities in the case of (1) out-of-network emergency care, (2) certain ancillary services provided at an in-network facility by an out-of-network provider, and (3) non- emergency care provided at an in-network facility by an out-of-network provider unless certain notice and consent requirements are met.
* Surprise billing prohibitions also apply to air ambulance services.
* Patients are only responsible for in-network rates and such payments are attributed to the patient’s in-network deductible.
* Out-of-network claims are subject to a 30-day open negotiation period followed by a binding arbitration process.
* Transparency requirements for health plans and providers relate to providing the patient coverage information, including updated directory information.
* Health plans are required to offer a price comparison tool for consumers.
* Grants will be available to create and improve state all payer claims databases.

**Addition Private Health Insurance Provisions**

* Gag Clause Prohibition – Bans gag clauses that prevent (1) enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers; or (2) plan sponsors from accessing de-identified claims data that may be shared under HIPAA business associate agreements with third parties for plan administration and quality improvement purposes.
* Disclosure of Broker and Consultant Fees – Requires health benefit brokers or consultants to disclose direct and indirect compensation to employer-sponsored health plans and enrollees in individual market plans.
* Parity Comparative Analyses - Requires group health plans and health insurance issuers offering coverage in the individual or group markets to conduct comparative analyses. HHS, Labor and Treasury may request to review analyses for their annual report and may issue corrective action plans for noncompliance.
* Pharmacy Benefits and Drug Costs Reporting - Requires health plans to report information to HHS, Labor and Treasury and HHS shall publish a biennial report of drug pricing and cost trends.

**For more detailed information on specific provisions, please reach out to:**

**Cathy Simmons Stephanie Collingwood**

**Executive Director, Government & External Affairs Government Relations Specialist**

**(319) 361-2336 (319) 538-8652**

**cathy.simmons@unitypoint.org****stephanie.collingwood2@unitypoint.org**