KHA Summary of Key Provisions in COVID-19 Stimulus Legislation

Provider Relief Fund

1. **Added $3 billion to the fund**

2. **Reporting of Losses:** Fully reverted to HHS FAQs which allow providers to use "any reasonable" method to calculate losses, as advocated by KHA. This allows Kentucky hospitals to argue that HRIP payments, due to being a new program, should be excluded due to being received in 2020 and not in 2019 and which may not have been budgeted due to the lateness of CMS approval in December 2019.

   "That for any reimbursement from the Provider Relief Fund to an eligible health care provider for health care related expenses or lost revenues that are attributable to coronavirus (including reimbursements made before the date of the enactment of this Act), such provider may calculate such lost revenues using the Frequently Asked Questions guidance released by the Department of Health and Human Services in June 2020, including the difference between such provider's budgeted and actual revenue budget if such budget had been established and approved prior to March 27, 2020"

3. **Transferability of Payments:** Permits targeted provider relief funds paid to a hospital in a system to be shared with the parent to cover other losses within the system, as advocated by KHA.

   "That for any reimbursement by the Secretary from the Provider Relief Fund to an eligible health care provider that is a subsidiary of a parent organization, the parent organization may allocate (through transfers or otherwise) all or any portion of such reimbursement among the subsidiary eligible health care providers or the parent organization, including reimbursements referred to by the Secretary as "Targeted Distribution payments, among subsidiary eligible health care providers of the parent organization except that responsibility for reporting the reallocated reimbursement shall remain with the original recipient of such reimbursement"

Medicaid DSH

1. **Cuts delayed for three years – through 2023, as advocated by KHA.** Cuts will be extended for additional future years beginning 2024 through 2027. There will not be a phase in to the cuts (previously the national cut was set at $4 billion for one year, increasing to $8 billion thereafter). The bill would immediately impose an $8 billion national cut in 2024, which would immediately reduce Kentucky's DSH allotment by 75% (in the first year of the cut and ongoing).

2. **Supplemental Payment Reporting –** By October 2021, HHS to establish a system for each state to submit data on supplemental payments, criteria for provider eligibility, the methodology used to distribute payments, the purpose and intended effects, timing, and an assurance of not exceeding the upper limit.

Medicare Rural Emergency Hospital (REH)

Sets up a new classification of a hospital for which Medicare provides reimbursement

1. **Rural emergency hospital (REH) services –** do not exceed an annual per patient average of 24 hours in the hospital. Includes ED and observation and other outpatient services that HHS specifies in regulations

2. **Enrollment -** To be a REH, must submit information to be enrolled which include:
   - **a.** Detailed transition plans (made available to the public) outlining services the hospital will keep, stop, add and modify and the outpatient services it will offer
   - **b.** Must have a transfer agreement with a Level I or II trauma center
   - **c.** Operate a "staffed ED", defined as an ED staffed 24/7 with an MD, NP, PA, or clinical nurse specialist
   - **d.** Meet CoPs that apply to critical access hospitals and hospital EDs that the HHS Secretary determines are applicable
   - **e.** If the hospital has a distinct part unit (DPU) which is a SNF, continue to meet requirements for the SNF
   - **f.** As of the date of enrollment, must be either:
     - **i.** A critical access hospital, or
     - **ii.** A PPS hospital with 50 or less beds, in a rural area or treated as being in a rural area
   - **g.** Must be licensed as a hospital under state laws or be approved by the state licensure agency as meeting the standards for licensure

3. **Quality Reporting –** HHS to establish measurements and reporting requirements (claims based measures and patient surveys). Measures are to be endorsed and HHS is to consider low volume in selection of measures

4. The change in licensure to a REH is not to impact **off campus HOPDs** of the facility

5. **EMTALA** is amended to include rural emergency hospitals

6. Qualifies a rural emergency hospital as a **telehealth** originating site

7. **Payment**
   - **a. Payment for Services Provided in an REH**
     - **i.** Payment for services will be the same as would apply for covered OP services under section 1833t (the OPPS for hospital outpatient department services) plus a 5% add-on
   - **b. Monthly Medicare Subsidy**
     - **i.** Medicare will calculate a per hospital subsidy according to this formula: difference between (1) total payments to CAHs in 2019 and (2) estimate of total payment that would have been paid to same hospitals if paid under the PPS for acute inpatient, outpatient and SNF divided by the number of CAHs in 2019
     - **ii.** Medicare will pay out the per hospital subsidy in monthly installments (1/12th each month)
     - **iii.** In future years, subsidy to reflect initial per hospital amount increased by CPI-U
     - **iv.** Hospital receiving a subsidy must keep information on how the additional payments are used (can be used to support the ED, operate the facility, support telehealth, etc.)
   - **c. Ambulance payment same as under section 1834(l) –** (HHS fee schedule for payment); DPU SNF payment same as section 1888(e) – Treatment of a DPU SNF in a hospital under cost report

Mental Health Parity/SUD Benefits

1. Health plans (including ERISA) that cover Medical/Surgical and mental health/SUD services and have non-quantitative treatment limits (NQTL) on Mental Health/SUD services must perform and document a comparative analysis of them 45 days after the effective date of the act, and plans must provide to state authorities.
2. The analysis must include:
   - specific coverage terms regarding NQTL and a description of the benefits that the terms apply to
   - Evidentiary standards used to design and apply NQTL
   - Analysis showing that the process, strategies, evidentiary standards used for the NQTL for mental health/SUD services are comparable and are not applied more strictly than for medical/surgical services
3. 18 months after the effective date, HHS is to issue guidance/regulations relating to Mental Health parity, including how to file complaints. The guidance document is to address how to improve compliance, including scenarios/examples of methods for determining appropriate types of NQTLs pertaining to medical necessity and appropriateness, use of fail first protocols, network and credentialing standards. HHS must give a 60 day public comment period on this guidance.

Surprise Billing – No Surprises Act

Implements a framework in line with KHA position to protect the patient and allow out-of-network payment to be resolved through negotiation and if needed, independent dispute resolution. Final language does NOT include provisions opposed by KHA that would have imposed unreasonable billing timeframes or allowances for patients to not pay bills received more than 90 days after their visit/discharge date.

1. **Effective Date - January 1, 2022**
2. **Coverage of ED Services –**
   - **a.** Health plans must cover ED services without prior authorization, regardless of provider participation status, and provide coverage that is no more restrictive or at no higher cost sharing than if the services were provided in-network.
   - **b.** Emergency services include services after a patient is stabilized and are part of outpatient observation or an inpatient or outpatient stay until the patient is able to travel using non-medical, non-emergency transportation and gives consent.
   - **c.** Non-participating ED providers are prohibited from balance billing more than in-network cost sharing
3. **Services Other Than ED –** Non-PAR providers may not balance bill a patient more than the in-network cost sharing for services provided at an in-network facility except as follows:
   - **a.** Out of network providers may balance bill for services outside of certain identified ancillary services, if certain notice and consent requirements are met
     - **i.** Ancillary services include emergency medicine, anesthesiology, pathology, radiology, neonatology, and diagnostic services (including lab and radiology) unless excepted by HHS in regulations.
   - **b.** The provider gives information they are nonparticipating, a good faith estimated amount of their charges, a list of any participating providers (if the services are to be received at a participating facility), whether prior authorization may be required, and obtains signed consent to be treated. To be obtained 72 hours before delivering the service
4. **Applicability -** Law applies to hospitals, CAHs, HOPDs, ASCs, and any other facilities specified by the HHS Secretary in regulations

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5. **Out of Network Payment –** Since KY has no state law mandating a specific out of network rate, the determination of out of network payment is made through open negotiation and if needed, independent dispute resolution (IDR).
   a. **Initial Payment –** Within 30 days of receiving the out of network provider's bill, the plan is to pay the provider directly an initial payment (their out of network rate), less patient cost sharing.
   b. **Open Negotiation:**
      i. The provider/facility or plan may, during the 30 day period beginning on the day the provider/facility receives an initial payment/notice of denial from the plan, initiate open negotiations to determine an agreed on amount.
      ii. The "open negotiation" period is the 30 day period beginning on the date that negotiations are initiated
      iii. If negotiations fail, an IDR may be initiated within 4 days from the first date after the last day of the open negotiation period
      iv. IDR is initiated by one of the parties giving notice to the other party and to the HHS Secretary (HHS to establish information to be submitted by regulation)
   c. **IDR –** Regulations for the IDR process are due by one year after the effective date of the Act (December 2021)
      i. The parties can still continue negotiations and arrive at an agreed on amount after IDR is requested and prior to an IDR determination. The IDR regulations will establish how to charge the parties for the cost of the IDR
      ii. Batching – the HHS Secretary will specify criteria under which multiple qualified dispute items can be considered jointly in a single IDR determination, but only if:
         1. Furnished by the same provider or facility
         2. Payment is owed by the same health plan/issuer
         3. Services are related to treatment of a similar condition
         4. The services/items were furnished during the 30 day period after the date on which the first item/service was furnished, or an alternative period determined by HHS for use in limited situations, such as low volume services. Services which are part of a bundled payment may also be part of a single IDR determination
      iii. **Certified Entity –**
         1. HHS will establish a process to certify IDR entities with sufficient medical and legal expertise and do not have a conflict of interest with an insurer or provider
         2. The process will allow the health plan and provider to jointly select a certified entity within 3 business days after the date of initiation of the process; the Secretary decides if no joint selection is made
      iv. **Payment Determination – Baseball Style Arbitration**
         1. To be made no later than 30 days after the IDR certified entity is selected
         2. No later than 10 days after the entity is selected, both parties are to submit an offer for payment, information requested by the entity, and each may submit any additional information relating to their offer
         3. The reviewer considers the following information in selecting the offer to be the final payment amount:
            a. "Qualifying payment amounts" that are comparable to the service which is the subject of the IDR
               i. "Qualifying payment amount" defined as:
                  1. For services given in 2022, the median of a health plan's contracted rates (for all plans

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offered in the same insurance market – large group, small group, individual; self-funded) on January 31, 2019, increased to 2022 by CPI-U, for the same/similar services in the geographic region

2. For services given in 2023+, the median of the plan's contracted rates in the prior year increased by CPI-U

ii. Calculation of Median Contracted Rate – HHS through regulations – that are due by July 1, 2021, will establish a methodology that health plans must use to determine the qualifying payment amount by individual, large group, and small group markets, and by geographic region. HHS is to consult with NAIC on establishment of geographic regions.

iii. Insufficient Information – if a plan does not have sufficient information to calculate a median in-network rate or insufficient information with respect to a particular service or provider type, an outside database is to be used, such as a state all payor claim database. FAIR Health could be used.

b. Additional information:

i. Level of training, experience and quality of the provider

ii. Non-participating provider's market share in the region

iii. Acuity of the patient and complexity of the service

iv. Teaching status, case mix, scope of services of the provider

v. Demonstrations of good faith efforts (or lack thereof) made by the provider and plan to enter into a network agreement

c. Information that may NOT be considered:

i. Usual and customary charges

ii. Reimbursement rate by Medicare, Medicaid, CHIP, TRICARE

d. IDR decision is binding and not subject to judicial review

e. The non-participating provider to be paid within 30 days of the final IDR determination

f. IDR Cost:

i. The losing party pays the cost of IDR. If Parties reach a settlement prior to the IDR decision, each pays ½ of the cost

ii. Each party to a determination where an IDR entity is selected must pay an administrative fee to HHS to cover HHS fees to administer the process

g. Suspension of Further IDR

i. The party submitting the initial notification for an IDR may not submit another notification involving the same other party for 90 days with respect to a service that was the subject of the initial notification

ii. HHS is to issue a report on the impact of this provision as to a pattern of practice of health plans routinely denying, reducing payment, downcoding of claims during this 90 day period.

h. Government Report to be provided on the process, types of services, offers selected, category or practice, geographic areas, etc.

6. **GAO Report on Adequacy of Provider Networks** (Due January 1, 2023), IDR Process, and on Surprise Billing which is to include impact on network participation, network adequacy standards, access including in rural areas

7. **Provider Disclosure on Protection Against Balance Billing – effective January 1, 2022**

a. Each provider and facility shall make publicly available and post on their website and provide to patients a one page notice (by mail or email) on the prohibitions on balance billing and how to contact state and federal agencies if they believe a provider is in violation

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b. Each state may require a provider or facility to follow the law. If a state does not enforce, then HHS will enforce. States may notify HHS of violations. HHS can apply CMPs not to exceed $10,000 per violation, but HHS is directed to waive penalties for inadvertent violations, or if the provider withdraws the bill that was in violation and refunds any wrong amount paid by the patient with interest.

c. HHS will also establish a complaint process

8. Ambulances

a. Air Ambulances – contains similar process for patients to pay in-network cost sharing and resolve payment through open negotiation and IDR. Air ambulances are required to report cost and other data to HHS. Establishes an Advisory Committee on Air Ambulance Quality and Patient Safety to make recommendations to Congress.

b. Ground Ambulances – The protections do not apply to ground EMS. HHS to establish an advisory committee to review options to improve disclosure of charges, inform consumers of insurance options and protection from balance billing.

9. Provider Discrimination

a. By January 1, 2022 HHS to issue regulations implementing protections of section 2706(a) of 42 USC 300gg-5(a) – This prohibits health plans from discriminating in network participation against providers acting within the scope of their license but allows plans to not contract with providers not willing to abide by the terms and conditions for participation. It also allows plans to vary reimbursement based on quality or performance measures.

b. HHS and FTC to issue study on patterns of vertical or horizontal integration of facilities, providers, health plans; health care costs; access including specialty services and in rural areas and recommend changes to address anti-competitive consolidation

10. Consumer Protections Through Health Plan Advance Cost Estimate (Advance EOB) – Effective January 1, 2022

a. Health Plans to give notice to enrollees about provider participation status, the contracted rate for in-network providers (based on billing codes received from the provider), how to find participating providers, the good faith estimate received from the provider/facility, a good faith estimate of the amount the plan will cover and the enrollee's cost sharing, and any UR requirements for coverage

11. Provider Furnished Information On Request – Effective January 1, 2022

a. Each health care provider and facility within certain timeframes of scheduling a service:

i. Ask about health plan coverage

ii. Send a good faith estimate of expected charges for the service (including items normally provided in conjunction with the service) with the expected billing and diagnostic codes to the patient's health plan or to the patient if they are uninsured

iii. This section reads as if this must be done for every scheduled service, not just upon request, although the legislative section title says "upon request"

b. Dispute Process for the Uninsured – HHS to establish a process to resolve disputes related to a good faith estimate and a provider's charges to uninsured individuals

12. Health Plan Price Comparison Tool – Effective January 1, 2022

a. Health plans to offer price comparison guidance by phone and on their website a price comparison tool showing an individual' cost sharing for services furnished by a participating provider

13. All Payor Claims Database

a. The HHS Secretary SHALL make one-time grants to eligible states to establish or improve a state all payer claims database.

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b. To be "eligible" a state shall submit an application and include how the state will ensure uniform data collection and protect privacy and security of the data.

c. Grants of $2.5 M over 3 years - $1M in each of the first 2 years

d. Authorized users of the data include:

i. Entities desiring to do research must submit description of uses and methodologies to evaluate health system performing using the data and approval by an IRB

ii. If an employer, health plan, TPA, or provider, requesting access for quality improvement or cost containment, a description of the intended uses for the data

iii. Employers may request customized reports at no cost from an all payer claims database that gets a grant

iv. States that get a grant must make available free of charge aggregate data sets to all authorized users

v. States can work with other states to establish a single application for access to data by users across multiple states

vi. No later than 1 year after the effective date (Dec 2021), HHS is to establish a standardized reporting format for voluntary reporting by group health plans to state all payer claims databases of medical claims, pharmacy claims, dental claims, and eligibility and provider files from private and public payers and guidance to states on how to collect this data

14. Health Plan Provider Directories – Health plans to verify and update its provider directory information at least every 90 days; and providers must have business practices to notify plans with information changes (at a minimum at the beginning of a network agreement, at termination, material changes)

15. Removal of Gag Clauses on Price and Quality Information

a. Health plans may not contract with a provider or association of providers where the contract would directly or indirectly restrict the plan from providing provider-specific cost or quality of care information such as through a pricing tool and accessing de-identified claims information for plan enrollees on providers, services and sharing that information with a business associate

Next Steps

The legislation calls for the HHS Secretary to issue a multitude of implementing regulations. KHA will turn its advocacy efforts to influencing these regulations to address concerns of Kentucky hospitals. We will be working with our Board, Reimbursement Committee, and various Forums to identify priorities for regulatory advocacy.

Kentucky Hospital Association

For more information about COVID-19 Stimulus Legislation, contact:

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