

## 21<sup>st</sup> Century Cures Act: Summary of Key Provisions Affecting Hospitals and Health Systems

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Medicare Provisions	
Section 4012, p. 410: Medicare hospital outpatient/ambulatory surgery site-of-service price transparency	Outpatient Price Transparency for Beneficiaries: For 2018 and thereafter, the Secretary of Health and Human Services (HHS) shall make publicly available on the Internet, in a searchable format, the estimated payment for outpatient covered services paid under the hospital outpatient department fee schedule and the ambulatory surgical center payment system, including the estimated amount of beneficiary cost sharing.
Section 4013, p. 412: Telehealth services in Medicare	<b>Sense of Congress:</b> Indicates the sense of the Congress that eligible originating sites and services should be expanded beyond current policy.
	<b>CMS report:</b> No later than one year from enactment, the Centers for Medicare and Medicaid Services (CMS) must submit a report to Congress on how expansion of Medicare telehealth services might improve care for patients, including dual-eligibles and those with chronic conditions.
	<b>MedPAC report:</b> By March 15, 2018, the Medicare Payment Advisory Commission (MedPAC) must submit a report to Congress on current Medicare payment policy for telehealth under fee-for-service and private health plans under Medicare and how payment for such services could be added under Medicare fee-for-service.
Section 15001, p. 758: Development of an inpatient-outpatient crosswalk similar hospital surgical services	To foster greater understanding of one-day hospital stays for surgeries, the bill requires the Secretary to develop a Healthcare Common Procedure Coding System (HCPCS) crosswalk that will allow classification of HCPCS-coded outpatient claims to inpatient-coded Medicare Severity-Diagnosis Related Groups (MS-DRGs) claims for not fewer than 10 surgical MS-DRGs. The crosswalk would be made publicly available by January 1, 2018.
Section 15002, p. 760: Establishing beneficiary equity under the Medicare Hospital Readmissions Reduction Program (RRP)	Socio-economic status (SES) risk adjustment to RRP: Beginning with discharges occurring during and after federal fiscal year (FFY) 2019, the Secretary shall separate hospitals into groups based on their overall inpatient populations that are fully, dually eligible for Medicare and Medicaid and compare hospitals within each group to calculate the adjustment. The methodology may be informed by MedPAC's June 2013 report to Congress. This is considered a transitional adjustment that the Secretary may alter

	Care Transformation (IMPACT) Act of 2014 on the effect of patient SES on quality measures and resource use. This adjustment is to be applied in a budget-neutral manner, meaning some hospitals across New York State and the nation would see lesser reductions under RRP while others would see greater reductions.
	Potential removal of certain readmissions: For discharges occurring after FFY 2018 the Secretary may consider removal as a readmission, an admission that is classified as one or more of the following: transplants, end-stage renal disease, burns, trauma, psychosis, or substance abuse. Allows the Secretary to consider further readmissions exclusions based on factors influencing health status, leveraging certain International Classification of Disease (ICD) diagnosis codes.
	<b>MedPAC to report to Congress</b> in its June 2018 report on whether readmissions are related to changes in outpatient and emergency services furnished.
Section 15005, p. 771: Hospital inpatient marketbasket reduction	Reduces the Medicare inpatient marketbasket update for discharges occurring during FFY 2018 by 0.04 percentage points to offset the cost of the hospital outpatient midbuild exception in Section 16001 (see below).
Sections 15004-15010, p. 768: LTCH	Includes several provisions that would affect long-term care hospitals (LTCHs),
provisions	including a reduction in outlier payments; mid-build exceptions to the moratorium on
p. c. i.e.	LTCH bed expansions; extension of the non-enforcement of the LTCH 25% rule;
	allowing newly established LTCHs to carve out certain discharges from the calculation of
	the 25-day average length of stay requirement; and the extension of certain exceptions
	from the LTCH/Inpatient Prospective Payment System (IPPS) site-neutral payment for
	LTCHs specializing in brain and spinal cord injuries and wound care.
Section 16001, p. 783: Continuing	Provides two, limited exceptions to Section 603, the hospital outpatient
Medicare payment under HOPD	department site-neutral reduction provision, of the Bipartisan Budget Act (BBA) of
Prospective Payment System for	2015 for provider-based, off-campus hospital outpatient departments (HOPDs).
services furnished by mid-build off-	(SMI) buildly assention. Allows for an assention to the site southed said assention
campus outpatient departments of providers	"Mid-build" exception: Allows for an exception to the site-neutral cuts for provider-
providers	based, off-campus HOPDs considered mid-build prior to November 2, 2015. Mid-build is defined as having a binding, written agreement with an outside party for the actual
	construction of the HOPD. A certification by the hospital chief executive officer/chief
	operating officer that the HOPD meets the definition must be submitted within 60 days
	after enactment. An attestation to CMS that the HOPD meets all of the provider-based
	criteria spelled out in 42 CFR 413.65 must be submitted by December 31, 2016 or if later, 60 days after enactment.

	Mid-build sites would be able to bill for OPD covered services starting in 2018 (2017 payment would be at the lower, site-neutral level spelled out in the Medicare OPPS final rule for 2017).
	<b>Attestation filed by December 2, 2015 exception:</b> Allows any off-campus HOPD that submitted to CMS a voluntary attestation to meeting the provider-based requirements prior to December 2, 2015, but had not yet begun billing under OPPS by that date, to receive the full HOPD payment rate beginning in 2017.
Section 16002, p. 787: Treatment of	Excepts PPS-exempt cancer hospitals from the HOPD site-neutral payment
cancer hospitals in off-campus	<b>changes</b> made under Section 603 of BBA and maintains that these cancer hospitals'
outpatient department of a provider	payments continue under their existing payment systems. Exempt cancer hospitals are
policy	also required to attest and the Secretary is required to audit the accuracy of the
	attestation for outpatient departments that meet the provider-based requirements after
	November 1, 2015. This exception would be implemented in a budget-neutral manner by
	reducing outpatient payment across all exempt-cancer hospitals.
Section 16004, p. 793: Critical Access	Prohibits the Secretary from enforcing the "direct supervision" regulations for
Hospital (CAH) relief from direct	calendar year 2016.
supervision enforcement	
Section 16003, p. 791: Meaningful Use	Establishes a multi-year exception from the MU and MIPS programs for eligible
(MU) and Merit-Based Incentive	professionals that furnish most all of their Medicare services in Ambulatory Surgical
Payment System (MIPS) exceptions	Centers (ASCs).
Section 17007, p. 823, Medicare Shared	Changes the assignment of Medicare beneficiaries to Accountable Care
Savings Program (MSSP) changes	<b>Organizations (ACOs) under MSSP</b> to include utilization from federally qualified health centers (FQHCs) or Rural Health Clinics (RHCs) in addition to the primary care services provided by ACO physicians.
<b>Use of Electronic Health Record</b>	Systems; Interoperability; Information Blocking
Section 4001, p. 328: Aims to reduce	Setting Goals to Reduce Burden: Amends the Health Information Technology for
electronic health record (EHR)	Economic and Clinical Health (HITECH) Act, requiring the Secretary to consult with
administrative burdens; encourages	providers and other stakeholders on goals and strategies to reduce regulatory or
certification for specialty providers;	administrative burdens related to use of electronic health records across numerous
requires release of MU attestation	programs and policies—including MU, MIPS, Advanced Alternative Payment Models,
statistics	Value-Based Payment, etc., within one year of enactment.
	Allows scribes to document in medical record: Specifies that physicians
	may delegate medical record documentation functions to a scribe if the physician has
	signed and verified the documentation.

Encourages certification of health IT systems for specialty providers, including pediatricians, and sites of service. MU Stats: Requires the Secretary to make publicly available MU attestation statistics by state, updated quarterly, within six months after enactment. Section 4002, p. 335: Condition of Condition of Certification: No later than one year from enactment, requires as a certification to discourage information condition of health IT system certification that IT developers or entities do not take any blocking: establishes EHR action that constitutes information blocking; have "published application programming interfaces and allow health information form such technology to be accessed. functionality reporting program exchanged, and used without special effort through the use of application programing interfaces or successor technology or standards . . . . " and, among other requirements, has undertaken real world testing. The Secretary may determine action to be taken in the case of noncompliance, including loss of certification. EHR developers must participate in a reporting program described below as a condition of certification. Allows MU providers to receive a hardship exemption from Medicare penalties for noncompliance should their EHR vendor lose certification under this section. EHR Functionality Reporting Program: No later than one year from enactment, stakeholders should be publicly engaged in the development of reporting criteria on EHR developer products including reporting on security, usability, interoperability, conformance to testing criteria, accessing and exchanging information from other healthcare providers or applicable users, etc. Reporting criteria will be used in a public reporting program to be run by independent entities awarded through a competitive bidding process, no later than one year from enactment. Section 4003, p. 350: Defines Defines interoperability and requires the National Coordinator for Health IT and the interoperability: requires National Institute of Standards and Technology and other relevant agencies in HHS to establishment of trusted exchange convene public-private partnerships to develop or support a common agreement of framework and common agreement on health information networks nationally. exchange; develop provider digital contact information index Establish trusted exchange framework: No later than six months from enactment, requires the National Coordinator to convene public and private stakeholders "to develop or support a trusted exchange framework for trust policies and practices and for the common agreement for exchange between health information networks," giving

consideration for adjudication of noncompliance and taking into consideration existing

frameworks and agreements to avoid disruption of such. The Secretary will give deference to private sector standard development organizations and voluntary consensus-based standards bodies. The framework will be pilot tested. The framework and common agreement will be published in *Federal Register* one year after the National Coordinator convenes stakeholders. Within two years of convening stakeholders, the National Coordinator must publish a list of health information networks that have voluntarily adopted the common agreement and are capable of trusted exchange.

As appropriate, federal agencies contracting or entering into agreements with health information exchange networks may require that as each such network upgrades health information technology or trust and operational practices, such network may adopt, where available, the trusted exchange framework and common agreement.

Provisions indicate there is no requirement that a health information network adopt the trusted exchange framework or common agreement for exchange of electronic health information between participants in the same network.

**Digital contact information index:** No later than three years from enactment, the Secretary shall directly or through partnership with a private entity, establish a provider digital contact information index for providers and facilities.

Redirects HIT Policy and Standards Advisory Committees to a single **HIT Advisory Committee.** Its priorities will reflect this section and engagement of stakeholders to identify priorities for standards adoption. Annual progress reports are required.

Section 4004, p. 382: Information blocking; establishes investigative process and penalty framework for providers, developers, and networks found to be information blocking

**Defines information blocking** as "a practice that . . . is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information." The definition emphasizes that information blocking occurs when a developer or provider either "knows, or should know" if their actions constitute information blocking. The Secretary shall identify reasonable and necessary activities that do not constitute information blocking. Clarifies that "health care providers are not penalized for the failure of developers of health information technology or other entities offering health information technology to such providers to ensure that such technology meets the requirements to be certified under this title."

	Establishes authority for the HHS Office of the Inspector General to investigate
	claims of information blocking by developers, providers, and health information
	exchanges or networks, and assign penalties for practices found to be interfering
	with the lawful sharing of EHRs.
	Penalties for developers and networks should not exceed \$1 million per violation;
	provider penalties will be determined by the appropriate federal agency as determined
	by the Secretary. The National Coordinator shall standardize a process whereby the
	public can submit a claim of information blocking.
Section 4005, p. 393: EHR exchange	EHR certification will require EHRs to be capable of transmitting to, receiving, and
with registries	accepting data from registries, including clinical-led clinical data registries.
	Adds developers of health IT to Patient Safety Organizations to help improve the safety
	of HIT products for patients.
Section 4006, p 396: Education and	Secretary and Office of Civil Rights will <b>educate providers</b> on leveraging health
guidance for providers and networks	information exchanges; clarifying misunderstandings about using exchanges.
on exchange and best practices of	intermediati exertainges, starrying misunderstandings about doing exertainges.
patient access to their health	The Office of Civil Rights will issue guidance to health information exchanges
information; certification may require	related to best practices of patient access to their health information in a private,
support to patient access	secure, verifiable, and easily exchanged way, given patient authorization requirements.
Support to patient addeds	Does not pre-empt state law on patient consent for access of information if such law
	providers greater protections than under federal law.
	providers greater protections than under rederal law.
	The National Coordinator may require certification criteria to support patient
	access to their electronic health information, "including in a single longitudinal format
	that is easy to understand, secure, and may be updated automatically," and patient
	reporting information.
Section 4007, p. 402: GAO study on	Requires the Government Accountability Office (GAO) to conduct a study on methods
patient matching	for securely matching patient records to the correct patient, no later than one year from
patient matering	enactment. A report to Congress must be submitted no later than two years from
	enactment.
Section 4008, p. 404: GAO study on	Requires GAO to review patient access to health information that includes information
patient access to health information	on complications healthcare providers experience when providing access. A report must
patient access to nearth information	
Section 11002 m 626; Clarification on	be submitted to Congress no later than 18 months from enactment.
Section 11003, p. 636: Clarification on	Directs the Secretary through the Director of the Office for Civil Rights to issue guidance
permitted use and disclosures of	no later than one year from enactment, that clarifies circumstances when a healthcare
protected health information	provider or covered entity may use or disclose protected health information related to the
	treatment of adults and minors with a mental health or substance use disorder.

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Section 16003, p. 791: Meaningful Use	Establishes a multi-year exception from the MU and MIPS programs for eligible
and MIPS Exceptions.	professionals that furnish most all of their Medicare services in ASCs.
Mental Health and Substance Abuse	
Section 1003, p. 27: Account for the	Provides \$1 billion over 2 years for grants to states to supplement opioid abuse
State Response to the Opioid Abuse	prevention and treatment activities, such as improving prescription drug monitoring
Crisis	programs, implementing prevention activities, training for health care providers, and
	expanding access to opioid treatment programs.
	Requires grantees to report on activities funded by the grant in the substance abuse
	block grant report.
Title VI, p. 455: Strengthening	Establishes an Assistant Secretary for Mental Health and Substance Use and Chief
Leadership and Accountability	Medical Officer within the Substance Abuse and Mental Health Services Administration
Restructuring Federal Behavioral	(SAMHSA).
Health Programs and Oversight	
	Provides for enhanced information dissemination, grant review, inter-agency
	collaboration; requires development of a strategic plan and biennial reports; reporting for
	Protection and Advocacy Organizations; creates coordinating committee to focus on
	serious mental illness (SMI).
Section 8001, p. 514: Community	Grants states additional flexibility to use CMHS block grant funding to provide
Mental Health Services Block Grant	community mental health services for adults with SMI and children with severe
	emotional disturbance (SED).
	Enhances requirements for state plans.
	Reauthorizes for fiscal years 2018-2022.
Section 8002, p. 525: Substance Abuse	Sets new state plan requirements, including describing how the state integrates
Prevention and Treatment Block Grant	substance use disorders with primary and mental health care.
	Reauthorizes for fiscal years 2018-2022
Section 9003, p. 541: Promoting	<b>Reauthorizes</b> grants to support integrated care models for fiscal years 2018-2022.
Integration of Primary and Behavioral	
Health Care	
Section 9005, p. 551: National Suicide	Continues the National Suicide Prevention Lifeline program, including maintaining a
Prevention Lifeline Program	suicide prevention hotline to link callers to local emergency, mental health, and social
	services resources.

Cootion 0007 in FEA. Ctromathoning	Authorized greats to strongth an appropriate board grising agency and
Section 9007, p. 554: Strengthening	Authorizes grants to strengthen community-based crisis response systems or to
Community Crisis Response Systems	develop, maintain or enhance a database of beds at inpatient psychiatric facilities, crisis
	stabilization units, and residential community mental health and residential substance
	use disorder treatment facilities.
Section 9014, p. 568: Assisted	Increases and extends authorization for Assisted Outpatient Treatment at \$15 million
Outpatient Treatment	in fiscal year 2017, \$20 million for fiscal year 2018, \$19 million for each of fiscal years
-	2019 and 2020, and \$18 million for each of fiscal years 2021 and 2022.
Section 9015, p. 569: Assertive	Establishes a grant program to support assertive community treatment programs for
Community Treatment	adults with SMI.
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	Authorizes appropriations of \$5 million for the period of fiscal years 2018-2022.
Section 9021, p. 575: Mental and	Reauthorizes grants to institutions of higher education or accredited professional
Behavioral Health Education Training	training programs for the recruitment and education of mental health care providers.
Grants	
	Establishes a priority for programs that train psychology, psychiatry, and social work
	professionals to work in integrated care settings.
Section 9022, p. 580: Strengthening the	Authorizes five-year grants through HRSA to train medical residents and fellows to
Mental and Substance Use Disorders	practice psychiatry and addiction medicine; and nurse practitioners, physician
Workforce	assistants, health service psychologists, and social workers to provide mental and
Workioroo	substance use disorder services in underserved community-based settings; and improve
	academic programs.
Section 9025, p. 593: Liability	Provides medical liability protections for volunteers at deemed Community Health
Protections for Health Professional	
	Centers to remove barriers for volunteering.
Volunteers at Community Health	
Centers	A 41 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Section 10002, p. 615: Increasing	Authorizes grants through HRSA to promote behavioral health integration in pediatric
Access to Pediatric Mental Health Care	primary care.
	Establishes requirements for statewide or regional pediatric mental health care
	telehealth programs.
	<b>Requires</b> the state receiving the grant to match at least 20 percent of the federal funds.
Section 10005, p. 626: Screening and	Establishes a grant program for screening assessment and treatment services for
Treatment for Maternal Depression	maternal depression, including providing appropriate training to health care providers
	and linkages to community-based resources.

	Prioritizes grants that improve or enhance access to screening services for maternal
	depression in primary care settings.
Section 10006, p. 628: Infant and Early	Creates a grant program for mental health prevention, intervention, and treatment
Childhood Mental Health Promotion,	programs for infants and children at significant risk of developing or showing early signs
Intervention, and Treatment	of mental disorders.
	<b>Requires</b> the state receiving the grant to match at least 10 percent of the federal funds.
Section 11001, p. 633: Clarification on	Sense of Congress: Clarification is needed on the existing uses and disclosures of
Health Information Disclosure	health information under the Health Information Portability and Accountability Act
	(HIPAA) by health care professionals to communicate with caregivers of adults with SMI
	to facilitate treatment.
Section 11002, p. 635: Confidentiality	Requires stakeholder review within a year of the final updated rules relating to
of Records	confidentiality of alcohol and drug abuse patient health records.
Section 11003, p.636: Clarification on	Directs the Director of the Office for Civil rights to clarify circumstances when a health
Permitted Uses and Disclosures of	care provider or covered entity may use or disclosure protected health information
Protected Health Information	related to the treatment of an adult with a mental or substance use disorder.
Section 11004, p. 639: Development	Authorizes funding to develop model training and educational programs to educate
and Dissemination of Model Training	health care providers, regulatory compliance staff, and others regarding the permitted
Programs	use and disclosure of health information under HIPAA.
Section 12001, p 642: Rule of	Clarifies that nothing in the Medicaid statute prohibits separate payment for the
Construction Related to Medicaid	provision of mental health and primary care services provided to an individual on the
Coverage of Mental Health Services	same day.
and Primary Care Services Furnished	
on the Same Day	
Section 12002, p. 643: Study and	Prompts a study and report on the provision of care to adults aged 21 to 65 enrolled in
Report Related to Medicaid Managed	Medicaid managed care plans receiving treatment for a mental health disorder in an
Care Regulation	IMD.
Institution for Mental Diseases (IMD)	
Exclusion	
Section 12003, p. 644: Guidance on	Directs CMS to provide guidance on opportunities to design innovative service delivery
Opportunities for Innovation	systems to improve care for individuals with serious mental illness or serious emotional
	disturbance.
Section 12004, p. 645: Study and	Directs a study and report on states that participated in the Medicaid Emergency
Report on Medicaid Emergency	Psychiatric Demonstration Project, which permitted payment for services provided to
Psychiatric Demonstration Project	Medicaid enrollees aged 21 to 64 receiving treatment for a mental health disorder in an
	IMD.

Section 12005, p.649: Providing EPSDT Services to Children in IMDS	<b>Effective</b> January 1, 2019, children receiving Medicaid-covered inpatient psychiatric hospital services are also eligible for the full range of early and periodic screening, diagnostic, and treatment services.
Section 12006, p. 650: Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid	<b>Directs</b> states to require the use of an electronic visit verification system for Medicaid-provided personal care services and home health services.
Section 13001, p. 657: Enhanced Compliance with Mental Health and Substance Use Disorder Coverage Requirements	<b>Requires</b> the issuance of compliance program guidance providing illustrative examples of past findings of compliance and noncompliance with existing mental health parity requirements, including disclosure requirements and non-quantitative treatment limitations.
	<b>Prompts</b> public comment on ways to improve consumer access to documents about mental health and substance use disorder benefits.
	<b>Clarifies</b> authority to audit health plans that have violated mental health parity laws five times.
Section 13002, p. 672: Action Plan for Enhanced Enforcement of Mental Health and Substance Use Disorder Coverage	<b>Requires</b> production of an action plan for improved federal and state coordination of parity requirements.
Section 13003, p. 677: Report on Investigations Regarding Parity in Mental Health and Substance Use Disorder Benefits	<b>Requires</b> CMS to conduct an annual report for five years summarizing the results of all closed federal investigations of parity violations.
Section 13004, p. 679: GAO study on Parity in Mental Health and Substance Use Disorders Benefits	Requires GAO to conduct a study on parity enforcement.
Section 13007, p. 683: Clarification of Existing Parity Rules	Clarifies coverage of eating disorders, including residential treatment.
Section 14012, p. 711: Co-occurring Substance Abuse and Mental Health Challenges in Residential Substance Abuse Treatment Programs	<b>Allows</b> state and local governments to use funds to develop and implement specialized residential substance abuse treatment programs that provide treatment to individuals with co-occurring mental health and substance abuse disorders.
Section 14013, p. 711: Mental Health and Drug Treatment Alternatives to	<b>Permits</b> state and local governments to use grant funds to create and operate programs that divert individuals with mental illness and co-occurring disorders from prisons and

Incarceration Programs	jails pursuant to a court-supervised intensive treatment program.
Section 14206, p. 746: GAO Report	<b>Requires</b> GAO to report on the practices that federal first responders, tactical units, and corrections officers use in responding to individuals with mental illness.
National Institutes of Health	
Various Section: National Institutes of Health Funding	Provides \$4.796 billion for fiscal years (FYs) 2017-26, including \$1.4 billion for the Precision Medicine Initiative, \$1.564 billion for the BRAIN Initiative, \$1.802 billion for cancer research and \$30 million for clinical research to further the field of regenerative medicine using adult stem cells.