High-Level Overview of Select Provisions in the Consolidated 2020 Omnibus Legislation

12/21/20 (subject to revisions)

E/M Changes and Physician Payment Adjustments

- **Mitigates budget neutrality cuts to physician payment and extends sequestration suspension:**
    - The legislation represents a significant win for physicians regarding Medicare physician payment. For Calendar Year 2021, the Medicare physician payment final rule indicated that there would be a 10.2% across-the-board reduction due to budget neutrality requirements. The new legislation dramatically reduces this budget neutrality adjustment in two ways:
    - (1) There will be an increase in the payment schedule of 3.75 percent. (This is applied across the board and without distinction to all payments under the Medicare physician payment schedule). This update is not subject to administrative or judicial review and shall not factor into future calculations of the fee schedule.
        - *To pay for this 3.75 percent increase, funds are to be drawn from the General Fund of the US Treasury (to the Federal Supplementary Medical Insurance Trust, or FSMIT) in the amount of $3 billion. Amounts needed in excess of the allocated $3 billion are to come from the FSMIT.*
        - *A report to Congress (Senate Finance + House W&M and E&M) is due on these payment increases by April 1, 2022.*
    - (2) Payments for HCPCS code G2211 are suspended for 3 years (through the end of December 2023).
        - *This code was finalized as an add-on code by CMS to account for visit complexity inherent to E/M visits. As calculated by the Medicare Physician Fee Schedule Final Rule, the G2211 code accounted for approximately $3 billion, or 3 percent of the reduction in the fee schedule. This delay in implementing the G2211 add-on code will further reduce the budget neutrality adjustment for 2021.*
    - Taken together, these provisions related to Medicare physician payment mean the budget neutrality adjustment is significantly reduced. Based on the specialty impact table in the final rule, the AMA estimates that most specialties will now see either a neutral or positive change in total Medicare payments in 2021. Impacts for particular medical practices will depend on both physician specialty

and their particular mix of services, as well as whether or not they would have billed G2211 if it were not delayed.
        - *Generally speaking, all physician specialties are in a better position in 2021 than if nothing were enacted. This is due to relentless advocacy on the impact of the reductions to physicians, especially during the COVID-19 pandemic.*
    - Additionally, the suspension of the Medicare Sequestration cut of 2 percent is continued. Originally set to end on December 31, 2020, the Medicare sequestration cut is pushed out and is now scheduled to end on March 31, 2021. This means, the 2 percent cut to Medicare payments is avoided for 3 months, which will provide a temporary but additional reprieve from a Medicare cut.
- **Temporary freeze of APM payment incentive thresholds.**
    - *The legislation also freezes the thresholds to qualify for the incentive payments for participating in Alternative Payment Models (APM) at their current levels for two years.*
    - *By preventing an increase in the statutory thresholds, more physicians will be able to qualify for the 5 percent APM lump sum incentive payment for 2023 and 2024 and avoid disqualification from failing to meet the standard.*
- **Employee retention tax credit modifications: Extends and Expands the CARES Act employee retention tax credit (ERTC).**
    - Beginning on January 1, 2021 and through June 30, 2021, the provision:
        - *Increases the credit rate from 50 percent to 70 percent of qualified wages*
        - *Expands eligibility for the credit by reducing the required year-over-year gross receipts decline from 50 percent to 20 percent and provides a safe harbor allowing employers to use prior quarter gross receipts to determine eligibility.*
        - *Increases the limit on per-employee creditable wages from $10,000 for the year to $10,000 for each quarter.*
        - *Increases the 100-employee delineation for determining the relevant qualified wage base to employers with 500 or fewer employees.*
        - *Allows certain public instrumentalities to claim the credit.*
        - *Provides rules to allow new employers who were not in existence for all or part of 2019 to be able to claim the credit.*
    - Retroactive to date noted in section of 2301 of the CARES Act, the provision:
        - *Provides that employers who receive Paycheck Protection Program (PPP) loans may still qualify for the ERTC with respect to wages that are not paid for with forgiven PPP proceeds.*
        - *Clarifies the determination of gross receipts for certain tax-exempt organizations.*
        - *Clarifies that group health plan expenses can be considered qualified wages even when no other wages are paid to the employee, consistent with IRS guidance.*
- **Additional Provider Relief:**

- $3 billion and new distribution requirements for the Provider Relief Fund.
- $1 billion in direct funds to the Indian Health Service to carry out services.

Surprise Billing Changes

The following is a summary of major changes from the previous version of the surprise billing bill (attached separately is a more detailed summary of the surprise billing provision):

- Clarification that an initial payment must be made to the physician, provider, or facility by the plan: The new language clarifies that an upfront, initial payment (or a notice of denial) is required to be made from the plan to the physician, provider, or facility.
  - *AMA expressed concern that the original language was ambiguous about whether a plan is required to make an initial payment to the physician.*
  - *This is an important clarification, especially for independent and smaller practices in that it ensures some cashflow into the practices regardless of whether the parties decide to challenge the payment through open negotiations or IDR.*
- Increase in the time allowed to initiate IDR from 2 days to 4 days: This change increases the time a physician has to initiate IDR following failed open negotiations.
  - *AMA argued that the original language (a 2-day period) was largely unworkable, especially if it fell over a weekend.*
- Payment standards that are excluded from the IDR entity's consideration when determining payment amount: The new language ensures that IDR entities will not consider Medicaid, Medicare, CHIP, and Tricare rates when evaluating the offers made by each party during the IDR process.
  - *The original language allowed for consideration of such rates while excluded UCR and billed charges, thereby skewing the decision in favor of the plans.*
  - *This change, advocated by the AMA, will help ensure fairer results from the IDR process and, more broadly, increase fairness in contract negotiations (as compared to the original language).*
- Removal of the timely billing requirements section:
  - *While the AMA did not oppose the goal of increasing the timeliness of bills to patients, we did highlight that many provisions in this original section failed to recognize the role of payers and other outside factors in adhering to the outlined timeline.*

Telehealth and Broadband Accessibility

- FCC COVID-19 Telehealth program:
  - *Additional $250 million appropriated for the program under the CARES act and increases transparency surrounding application review*
- Amendments to the Secure and Trusted Communications Network Reimbursement Program
  - *Compensates providers for the cost of removing and replacing certain unsecure equipment from their network.*
- Broadband Access:

    - *Establishes the Office of Internet Connectivity and Growth (Office) at the NTIA. This Office would be tasked with performing certain responsibilities related to broadband access, adoption, and deployment, such as performing public outreach to promote access and adoption of high-speed broadband service, and streamlining and standardizing the process for applying for Federal broadband support.*
    - *Provides more than $730 million in the expansion of broadband service to provide economic development opportunities and improved education and healthcare services.*
    - *Establishes the Emergency Broadband Benefit Program at the FCC, under which eligible households may receive a discount of up to $50, or up to $75 on Tribal lands, off the cost of internet service and a subsidy for low-cost devices such as computers and tablets.*
    - *Establishes two grant programs at the NTIA.*
- Connecting Minority Communities.
    - *Establishes an Office of Minority Broadband Initiatives at the National Telecommunications and Information Administration (NTIA) to focus on broadband access and adoption at Historically Black colleges or universities, Tribal colleges and universities, and other Minority-serving institutions.*
- Expanding access to mental health services furnished through telehealth.
    - *Allows beneficiaries to receive mental health services via telehealth, including from the beneficiary's home.*
    - *To be eligible to receive these services via telehealth, the beneficiary must have been seen in person at least once by the physician or non-physician practitioner during the six months period prior to the first telehealth service.*
- The AI in Government Act of 2020.
    - *Codifies the AI Center of Excellence within the General Services Administration to advise and promote the efforts of the federal government in developing innovative uses of artificial intelligence (AI) and competency in the use of AI in the federal government.*
- Other AI Related Provisions
    - *Requires the Secretary of Energy to carry out a research program in artificial intelligence and high-performance computing focused on developing tools to solve big data challenges associated with veterans' health care.*
    - *Seedling investment in next-generation microelectronics in support of artificial intelligence.*
    - *Assessment of critical technology trends relating to artificial intelligence, microchips, and semiconductors and related matters.*

<u>New Medicare Provisions</u>

- Improves measurements under the skilled nursing facility value-based purchasing program.

    - *Allows Secretary to add up to 10 quality measures for facilities with more than the required minimum number of cases.*
- Requires certain manufacturers to report drug pricing information with respect to drugs under the Medicare program.
- Continued coverage of certain temporary transitional home infusion therapy services.
- Waives Medicare coinsurance for certain colorectal cancer screening tests.
    - *This section gradually eliminates cost-sharing for Medicare beneficiaries with respect to colorectal cancer screening tests where a polyp is detected and removed.*
- Delays implementation of the radiation oncology model under the Medicare program to January 1, 2022.
    - *Along with the radiation oncology specialty societies, the AMA successfully advocated for CMS to delay implementation of the mandatory radiation oncology alternative payment model.*
- Permits direct payment to physician assistants under Medicare for services furnished on or after January 1, 2022.
- Waives budget neutrality for establishing new payment classes of oxygen and oxygen equipment.
- Extends months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions.

<u>Medicare Specific Extenders</u>

- Extension of the work geographic index floor under the Medicare program to January 1, 2024.
- Extension of funding for quality measure endorsement, input, and selection.
    - *Additional $66 million to CMS for quality measure selection to October 1, 2023*
- Extension of funding outreach and assistance for low-income programs to October 1, 2023.
    - *Additional $50 million in funding for each fiscal year 2021-2023.*
- Extension of Medicare patient IVIG access demonstration project to January 1, 2024.
    - *Allowing up to 2500 additional Medicare patients to enroll.*
- Extending the Independence at Home medical practice demonstration program to January 1, 2024.
    - *Expands size to 20,000 beneficiaries.*

<u>Medicaid</u>

- Eliminates DSH reductions for fiscal years 2021 through 2023.
- Rescission of $3,464,000,000 from the Medicaid Improvement Fund.
- Medicaid coverage of certain medical transportation.
    - *Provides coverage for certain non-emergency medical transportation to and from providers.*

- Promoting access to life-saving therapies for Medicaid enrollees by ensuring coverage of routine patient costs for items and services furnished in connection with participation in qualifying clinical trials.
- Medicaid Extenders:
    - *Extension of Money Follows the Person Rebalancing Demonstration.*
    - *Extension of spousal impoverishment protections.*
    - *Extension of community mental health services demonstration program.*

Price Transparency

- Increases transparency by removing gag clauses on price and quality information.
    - *Also bans gag clauses in contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared, under Health Insurance Portability and Accountability Act (HIPAA) business associate agreements, with third parties for plan administration and quality improvement purposes.*
- Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market.
    - *Requires health benefit brokers and consultants to disclose to plan sponsors any direct or indirect compensation the brokers and consultants may receive for referral of services.*
- Includes new provisions designated to strengthen parity in mental health and substance use disorder benefits.
    - *Requires group health plans and health insurance issuers offering coverage in the individual or group markets to conduct comparative analyses of the nonquantitative treatment limitations used for medical and surgical benefits as compared to mental health and substance use disorder benefits.*
    - *It requires the Secretaries of HHS, Labor, and the Treasury to request comparative analyses of at least 20 plans per year that involve potential violations of mental health parity, complaints regarding noncompliance with mental health parity, and any other instances in which the Secretaries determine appropriate.*
- Adds provisions regarding reporting on pharmacy benefits and drug costs.

Graduate Medical Education

- $22.7 billion for the Higher Education Emergency Relief Fund
    - $20.2 billion for public and private, non-profit institutions of higher education, including those that serve students enrolled exclusively in distance education, to be distributed by a formula taking into account head count and full-time equivalent enrollment
    - $1.7 billion for Historically Black Colleges and Universities, Tribal Colleges and Universities, Hispanic Serving Institutions, and certain other institutions.
    - $113 million for institutions of higher education with unmet need
    - Cap on funding for proprietary institutions and restrictions on use of funds.

- Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations.
    - *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).*
- Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs.
- Promoting rural hospital GME funding opportunity.
    - *This section makes changes to Medicare graduate medical education (GME) Rural Training Tracks (RTT) program in order to provide greater flexibility for hospitals not located in a rural area that established or establishes a medical residency training program (or rural tracks) in a rural area or establishes an accredited program where greater than 50 percent of the program occurs in a rural area to partner with rural hospitals and address the physician workforce needs of rural areas.*
- Distribution of additional 1,000 residency positions:
    - *Supports Medicare physician workforce development by providing for the distribution of 1,000 additional Medicare-funded graduate medical education (GME) residency positions.*
    - *Not less than 10 percent of the aggregate number of these new positions will be given to rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions.*
- Strategy to prioritize and expand educational and professional exchange programs with Mexico.
    - *Assess the feasibility of fostering partnerships between universities in the United States and medical school and nursing programs in Mexico to ensure that medical school and nursing programs in Mexico have comparable accreditation standards as medical school and nursing programs in the United States by the Accreditation and Standards in Foreign Medical Education, in addition to the Accreditation Commission For Education in Nursing, so that medical students can pass medical licensing board exams, and nursing students can pass nursing licensing exams, in the United States.*
- $50,000,000 will be available for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions.

<u>Rural Health Care Facilities</u>

- Medicare Payment for Rural Emergency Hospital Services:
    - *Creates a new, voluntary Medicare payment designation that allows either a Critical Access Hospital (CAH) or a small, rural hospital with less than 50 beds to convert to a Rural Emergency Hospital (REH).*

    - *REHs can also furnish additional medical services needed in their community such as observation care, outpatient hospital services, telehealth services, ambulance services, and skilled nursing facility services.*
    - *REHs will be reimbursed under all applicable Medicare prospective payment systems plus an additional monthly facility payment and an add-on payment for hospital outpatient services.*
- Improving Rural Health Clinic payments:
    - *Phases-in a steady 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.*
    - *Ensures that no RHC would see a reduction in reimbursement.*
    - *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. This brings the RHC upper limit roughly in line with the Federally Qualified Health Centers (FQHC) Medicare base rate.*
- Medicare payment for certain Federally Qualified Health Center and Rural Health Clinic services furnished to hospice patients:
    - *Allows Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to furnish and bill for hospice attending physician services when RHC and FQHC patients become terminally ill and elect the hospice benefit beginning January 1, 2022.*
- Five-year extension of the Rural Community Hospital Demonstration.
- Extension of the Frontier Community Health Integration Project demonstration by five years.

<u>Small Businesses</u>

- Changes to the Paycheck Protection Program (PPP):
    - *An additional $284 billion for PPP and extends through March 31, 2021.*
    - *Expands PPP eligibility for more critical access hospitals and 501(c)(6) nonprofits; provides a second PPP forgivable loan for the hardest-hit small businesses and non-profits with 300 or few*
    - *er employees and that can demonstrate a loss of 25% of gross receipts in any quarter during 2020 when compared to the same quarter in 2019.*
    - *Repeals the requirement of deducting an EIDL Advance from the PPP forgiveness amount; specifies that forgiven Paycheck Protection Program (PPP) loans will not be included in taxable income. It also clarifies that deductions are allowed for expenses paid with proceeds of a forgiven PPP loan, effective as of the date of enactment of the CARES Act and applicable to subsequent PPP loans.*
- Provisioning of an additional $20 billion for EIDL Advance Grants.
    - *Small businesses and nonprofits in low-income communities are eligible to receive $10,000 grants, previous recipients are also eligible to receive the full $10,000 if their award was less in the first round of grants.*
- Extended SBA Debt Relief Payments:

- *Provides $3.5 billion dollars to resume debt relief payments of principal and interest (P&I) on small business loans guaranteed by the SBA under the 7(a), 504 and microloan programs.*
- *All borrowers with qualifying loans approved by the SBA prior to the CARES Act will receive an additional three months of P&I, starting in February 2021 with payments capped at $9,000 per borrower per month.*
- *SBA payments of P&I on the first 6 months of newly approved loans will resume for all loans approved between February 1 and September 30, 2021, also capped at $9,000 per month.*

- Enhancements of SBA Lending Programs:
  - *Provides $2 billion to enhance SBA's core programs, $57 million for the SBA Microloan Program, and $64 million in microloans for minority-owned and underserved small businesses.*

<u>Public Health Provisions</u>

- Health Care COVID Relief Spending: Vaccines, Testing and Tracing, Community Health and Health Care Provider Support.
  - *$20 billion to BARDA for procurement of vaccines and therapeutics.*
  - *Nearly $9 billion to the CDC and states for vaccine distribution.*
  - *More than $3 billion for the strategic national stockpile, including $300 million specifically directed to high risk and underserved areas for distribution, including communities of color.*
  - *More than $22 billion, all sent directly to states, for testing, tracing and COVID mitigation programs.*
    - *Of this total, $2.5 billion will be sent out as grants specifically targeted at needs in underserved areas, including both communities of color and rural communities.*
  - *$4.5 billion for investment in mental health funding.*
  - *More than $1 billion appropriated to the NIH for COVID-19*
- Improving awareness of disease prevention:
  - *Authorizes a national campaign to increase awareness and knowledge of the safety and effectiveness of vaccines for the prevention and control of diseases, to combat misinformation, and to disseminate scientific and evidence-based vaccine-related information,*
- Expanding capacity for health outcomes:
  - *Grants awarded to eligible entities in order to evaluate, develop, and, as appropriate, expand the use of technology-enabled collaborative learning and capacity building models.*
- Supporting public health data system modernization.
  - R*equires HHS to expand, enhance, and improve public health data systems used by the Centers for Disease Control and Prevention (CDC). It also requires HHS to award grants to State, local, Tribal, or territorial public health departments for the modernization of public health data systems.*

- Native American Suicide Prevention:
    - *Entities that apply for a grant or cooperative agreement under this section must consult or confer with certain entities and Native Hawaiian Health Care Systems, as applicable, in the applicable State with respect to the development and implementation of a statewide early intervention strategy.*
- Guidance on evidence-based strategies for public health department obesity prevention programs.
- Reauthorization of school-based health centers with funding through fiscal year 2026.
- Extends funding for Special Diabetes to December 18, 2023.
- Reauthorization of the Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009.

<u>Other Noteworthy Provisions</u>

- VA Funding
    - *Provides $90 billion in funding for patient care in addition to another $2.6 billion for implementation of the new VA electronic health record system.*
- Requiring certain manufacturers to report drug pricing information with respect to drugs under the Medicare program.
    - *Authorizes Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) to have access to certain drug pricing data for purposes of monitoring, analysis, and making program recommendations.*
- Modernizing the labeling of certain generic drugs:
    - *Amends Federal Food, Drug, and Cosmetic Act by addition of section regarding process to update labeling for certain generic drugs.*
- Emergency Rental Assistance:
    - *Extension of the CDC rental eviction moratorium through January 31, 2021.*
- Temporary special rules for health and dependent care flexible spending arrangements
    - *Provides further flexibility for taxpayers to rollover unused amounts in their health and dependent care flexible spending arrangements from 2020 to 2021 and from 2021 to 2022.*
- Preventing Online Sales of E-Cigarettes to Children
    - *Amends current law to curb online sales of e-cigarettes to minors by bringing such sales under the federal regulations applying to the sale of tobacco products by extending the current definition of a "cigarette" to include any "electronic nicotine delivery system," such as an e-cigarette*.
    - *Requires the U.S. Postal Service, not later than 120 days after the date of enactment, to promulgate regulations to clarify that the prohibition on mailing cigarettes includes electronic nicotine delivery systems*
- Extension of Temporary Assistance for Needy Families (TANF) through end of fiscal year 2021.

- Provides $12.5 million to the CDC, the same amount as the 2020 enacted level, to specifically support firearm injury and mortality prevention research, and another $12.5 million to the NIH for such research.
- Food and Nutrition Programs:
    - *Fully funds participation in both WIC and SNAP and increases funding for the school lunch program.*
- Health Professionals Opportunity Grant:
    - *Provides administrative funding for HHS ($3.6 million) to carry out grants made sunder Section 2008(a) of the Social Security Act and for research, evaluation, and reporting, and for necessary administrative expenses to carry out these activities.*
- $4,000,000 for the establishment of a national center on forensics at an accredited university of higher education with affiliate medical and law schools, in partnership with a co-located full-service State department of forensic science with a medical examiner function.
- $448,805,000 for carrying out the Immigration and Nationality Act and Refugee Education Assistance Act, with respect to immunization and respiratory diseases.