CORONAVIRUS RELIEF BILL SUMMARY

Provider Funding

- $3 billion for the Provider Relief Fund. Language is included directing 85% of unobligated balances or funds recovered to be for future distributions based on applications that consider financial losses and changes in operating expenses occurring in the third or fourth quarter of calendar year 2020, or the first quarter of calendar year 2021. Language is also included clarifying the definition of lost revenue for hospitals and allows hospital systems to transfer COVID funds among hospitals in their system.
- Temporary suspension of Medicare sequestration that is set to expire on December 31, 2020, increasing payment to all providers by 2 percent for first three months of 2021.
- To respond to the concerns about the effects of the CY 2021 physician fee schedule's budget neutrality rules, the bill:
    - Prohibits HHS from making payments under the Physician Fee Schedule for services described by HCPCS code G2211 (or any successor or substantially similar code) prior to January 1, 2024.
    - Adds $3 billion into the physician fee schedule in 2021, resulting in payment increases across the board.
    - Freezes the current payment and patient count thresholds for physicians and other eligible clinicians participating in APMs to receive a five percent incentive payment in payment years 2023 and 2024 (for performance years 2021 and 2022). It also freezes the Partial Qualifying APM participant payment threshold and the patient count threshold at current levels for performance years 2021 and 2022 (and payment years 2022 and 2023).

Surprise Billing and Price Transparency

- The legislation prohibits certain out-of-network providers from balance billing patients unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care.
- The legislation creates a framework that allows health care providers and insurers to resolve payment disputes either through negotiation between the parties or arbitration. There is no minimum payment threshold to enter IDR and the arbiter is prohibited from considering Medicare and Medicaid rates in the process.
- Other patient protections included are an Advance Explanation of Benefits for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the expected cost, and the network status of the providers; a 90 day continuity of coverage for patients with complex care whose provider changes network status; the maintenance of a price comparison tool for patients, and up-to-date provider directories.
- The legislation establishes a grant program to create and improve State All Payer Claims Databases, which collect de-identified patient health care data so patients, states, and employers are able to better understand their health care costs and take steps to reduce those costs.
- Bans "gag clauses" between providers and insurers that bars enrollees from viewing cost and quality data on providers. Contracts also cannot include clauses that prevent plan

sponsors from accessing de-identified claims for plan administration and quality improvement purposes.

- Requires health benefit brokers and consultants to inform people buying coverage in the individual market, including short-term plans, of any direct or indirect compensation they're getting for referrals.
- Requires HHS, Treasury, and the Department of Labor to analyze nonquantitative limits to medical and surgical benefits compared to mental health benefits for at least 20 insurance plans a year and publish a report. Any insurers found non-compliant must create and implement a corrective action plan.
- Mandates that health plans report information on plans' medical costs and drug spending to HHS, Labor and Treasury. HHS also must publish a report on drug pricing trends and their contribution to health insurance premiums. The report is due within 18 months of the bill's enactment and every two years afterward.

Medicare Policies

- Allows the Secretary to add up to 10 quality measures, including measures of functional status, patient safety, care coordination, or patient experience, to the skilled nursing facility value-based purchasing program for facilities with more than the required minimum number of cases.
- Requires HHS, no later than January 1, 2022, to allow 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.
- Requires HHS to conduct outreach to Medicare providers and practitioners regarding Medicare payment for cognitive assessment and care plan services furnished to individuals with cognitive impairment, such as Alzheimer's and related dementias.
- Provides continued coverage of home infusion therapy services for beneficiaries 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.
- Allows direct payment under the Medicare program to physician assistants for services furnished to beneficiaries on or after January 1, 2022.
- Permanently authorizes, beginning January 1, 2024, the Limited Income Newly Eligible Transition demonstration to provide immediate temporary Part D coverage for certain individuals with low-income subsidies while their eligibility is processed.
- Requires Part D plan sponsors to implement real-time benefit tools that are capable of integrating with provider electronic prescribing and EHR systems.
- Eliminates coverage gaps in Medicare by requiring that Part B insurance coverage begins the first of the month following an individual's enrollment and provides for a Part A and Part B Special Enrollment Period for "exceptional circumstances," such as hurricanes and other natural disasters, to mirror authority in Medicare Advantage and Medicare Part D.
- Gradually eliminates cost-sharing for Medicare beneficiaries with respect to colorectal cancer screening tests where a polyp is detected and removed.
- Codifies an existing mechanism used within CMS as part of the agency's ongoing responsibility to combat fraud, waste, and abuse.

- Allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent FTE resident cap or a Per Resident Amount.
- Provides for a statutory six-month additional delay, in addition to the delay announced by CMS of the Medicare radiation oncology model to January 1, 2022.
- Adds blood clotting factors and items and services related to their furnishing to the categories of high-cost, low-probability services that are excluded from the skilled nursing facility per diem prospective payment system and are separately payable. This change will allow SNF care to be an option instead of continued inpatient care for this limited population.
- Requires all manufacturers of drugs covered under Medicare Part B to report average sales price information to HHS beginning on January 1, 2022. Specifically, it adds a new requirement under Part B for manufacturers that do not have a rebate agreement through the Medicaid Drug Rebate Program to report ASP information.
- Establishes eligibility for immunosuppressive drug coverage through Medicare to post-kidney transplant individuals whose entitlement to benefits under part A ends (whether before, on, or after January 1, 2023) and who do not receive coverage of immunosuppressive drugs through other insurance.
- Extends the change to the annual updates to the hospice aggregate cap made in the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 and applies the hospice payment update percentage rather than the Consumer Price Index for Urban Consumers to the hospice aggregate cap for fiscal years 2026 through 2030.
- Authorizes CMS, when determining payment for products covered under Medicare Part B, to review and exclude payments improperly made for self-administered version of products that are not covered under Part B when they are self-administered.
- Makes changes to the Medicare hospice survey and certification process to improve consistency and oversight, allowing the Secretary to use intermediate remedies to enforce compliance with hospice requirements and extending the requirement that hospices be surveyed no less frequently than once every 36 months. It also creates a new Special Focus Facility Program for poor-performing hospice providers, who will be surveyed not less frequently than once every six months. It increases the penalty for hospices not reporting quality data to the Secretary from two to four percentage points, beginning in fiscal year 2024.

Rural-Related Medicare Policies

- Creates a new, voluntary Medicare payment designation that allows either a Critical Access Hospital or a small, rural hospital with less than 50 beds to convert to a Rural Emergency Hospital (REH) to preserve beneficiary access to emergency medical care in rural areas that can no longer support a fully operational inpatient hospital. 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.

- Makes changes to Medicare graduate medical education Rural Training Tracks program in order to provide greater flexibility for rural and urban hospitals to partner and address the physician workforce needs of rural areas.
- 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. It ensures that no RHC would see a reduction in reimbursement. RHCs with an all-inclusive rate (AIR) 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 MEI. 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. This brings the RHC upper limit roughly in line with the Federally Qualified Health Centers (FQHC) Medicare base rate. In each subsequent calendar year, starting in 2029, the new statutorily set RHC cap would revert back to an annual MEI inflationary adjustment.
- Allows RHCs and 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. As a result, Medicare beneficiaries will continue to receive hospice-related care from their known provider.
- Expands access to telehealth services in Medicare to allow 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, with additional face-to-face requirements determined by the Secretary.
- Provides for the distribution of additional Medicare-funded graduate medical education residency positions. Rural hospitals, hospitals that already above their Medicare cap for residency positions, hospitals in states with new medical schools, and hospitals that serve Health Professional Shortage Areas will be eligible for these new positions.
- Extends the Rural Community Hospital Demonstration by five years.
- Extends the Frontier Community Health Integration Project (FCHIP) demonstration by five years.
- Specifies that the budget neutrality requirement for establishing new payment classes of oxygen and oxygen equipment no longer applies, thereby increasing payment for certain oxygen equipment in rural areas.

<u>Medicaid Policies</u>

- Cuts in Medicaid DSH allotments are delayed until 2024.
- Repeal and Replacement of 2017 Medicaid DSH Cap Rule. CMS's 2017 rule for calculating DSH caps is repealed effective October 1, 2021. As of October 1, 2021, with regard to DSH payments made during federal fiscal years beginning on or after that date, a hospital's DSH cap is to be calculated by determining the costs incurred by the hospital during the year of furnishing hospital services to:
    - Individuals who are eligible for medical assistance under the State plan or a waiver of such plan and for whom the State plan or waiver is the primary payor for such services; or

    - Individuals who have no health insurance, or other source of third party coverage, for services provided during the year, as determined by the Secretary.
- New Data Reporting Requirements for UPL and other Supplemental Medicaid Payment Programs. HHS, not later than October 1, 2021, shall establish a system for each State to submit reports, as determined appropriate by the Secretary, on supplemental payments data, as a requirement for a State plan or State plan amendment that would provide for a supplemental payment. "Supplemental payment" is defined to mean a payment to a provider that is in addition to any base payment made to the provider under a Medicaid State Plan or Medicaid demonstration authority (this would include UPL payments), but not including DSH payments. Nothing in the legislation governs the use of IGTs, or how a State may organize and maintain its supplemental payment programs. The legislation only deals with reporting requirements. In this regard, however, the Secretary is given a lot of flexibility in determining the scope and nature of such reporting requirements.
- Money Follows the Person demonstration will receive $450 million per fiscal year through fiscal 2023. It changes the institutional residency period from 90 days to 60 days, updates the state application requirements to provide additional information on the use of rebalancing funds, and requires HHS to issue a report on best practices.
- Requires state Medicaid programs cover nonemergency medical transportation to necessary services. States must "comply with certain program integrity standards" and CMS must "convene stakeholder meetings to address certain challenges regarding Medicaid program integrity and coverage of such services."
- Extends spousal impoverishment protections and community mental health services demonstration until 2023.
- Clarifies the authority of state Medicaid fraud and abuse control units to investigate and prosecute cases of Medicaid patient abuse and neglect in any setting.

Public Health Extenders

- Funds the Special Diabetes Programs, National Health Service Corps, community health centers, and the teaching health center graduate medical education program at current levels through FY 2023.

Medicare Extenders

- Increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average through December 31, 2023.
- Provides $66 million in funding to for quality measure selection and to contract with a consensus-based entity to carry out duties related to quality measurement and performance improvement through September 30, 2023. It also includes additional reporting requirements, facilitates measure removal, and prioritizes maternal morbidity and mortality measure endorsement.
- Extends funding for low-income Medicare beneficiary outreach, enrollment, and education activities provided through State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits and Outreach and Enrollment through September 30, 2023. It provides $50 million in funding for each of fiscal years 2021, 2022, and 2023.
- Extends the Intravenous Immunoglobulin (IVIG) treatment demonstration that is administered in the home through December 31, 2023, allowing to up to 2500 additional

Medicare patients with primary immunodeficiency diseases (PIDD) to enroll and requiring an updated evaluation of the demonstration.
- Extends the Independence at Home demonstration for three additional years (through December 31, 2023) and expands the size of the demonstration from 15,000 beneficiaries to 20,000 beneficiaries.
- Extends through March 14, 2021 a provision in the CARES Act which amended the Families First Coronavirus Response Act to provide federal support to cover 50% of the costs of unemployment benefits for employees of state and local governments and non-profit organizations.
- $8.75 billion to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage. Of this amount, $4.5 billion goes directly to states, localities, and territories; $210 million is transferred to the Indian Health Service; and $300 million is for high-risk and underserved populations.
- Mental Health Services Block Grant - $1.650 billion, of which, no less than 50 percent of funds shall be directed to behavioral health providers
- Substance Abuse and Prevention Treatment Block Grant - $1.650 billion
- Certified Community Behavioral Health Clinics - $600 million
- Covid Testing - $22.4 billion for testing, contact tracing, and surveillance. Of this amount, $2.5 billion is for high risk and underserved populations and $790 million is transferred to the Indian Health Service
- BARDA - $19.695 billion for vaccine, therapeutic, and diagnostic development

Paid Leave Credits

- Extend credits for paid sick and family leave provided under the FFCRA through March 31, 2021.

Payroll Tax Deferral

- Workers who've had their payroll taxes deferred since September would be given until Dec. 31, 2021, to repay the government, instead of through April 30, 2021, as originally directed by the Treasury Department.