

The Consolidated Appropriations Act of 2021 includes COVID-19 relief legislation. Following are high-level summaries that may be of interest to APMA members. APMA will continue to review the legislation and provide information to members.

Medicare Physician Fee Schedule

- The COVID relief legislation provides for a one-time, one-year increase in the Medicare physician fee schedule of 3.75 percent to support physicians and other professionals in adjusting to changes in the Medicare physician fee schedule during 2021, and to provide relief during the COVID-19 public health emergency. APMA will update members further when CMS issues guidance. This one-time increase was a result of the advocacy efforts of APMA and its coalition partners in urging Congress to address the decrease in the Medicare Physician Fee Schedule caused by Medicare's budget neutrality requirements.
- Congress also issued a three-year moratorium on HCPCS Code G2211, and prohibited CMS from making payments prior to January 1, 2024, for this inherent complexity add-on code. HCPCS Code G2211 was finalized in the CY 2021 Medicare Physician Fee Schedule, and APMA had previously urged CMS and Congress to postpone implementation of this code (formerly referred to as GPC1X). APMA, along with AMA and other medical specialties, stated that this code was not clearly defined, and CMS over-estimated its assumption on the utilization, which negatively impacted the conversion factor and in turn caused a decrease in other codes as a result of Medicare's budget neutrality requirements.
- Congress also extended Sequestration relief for three months. The CARES Act suspended the Medicare Sequestration cuts for all Medicare fee-for-service claims until the end of the year, and the latest COVID-relief extends the suspension. While APMA appreciates this short-term relief, APMA has long advocated for Congress to end the Sequestration cuts.

More information:

<https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/OMNIFINALMedicareMedicaidHumanServicesExtendersPackageSBS.pdf>

Provider Relief Fund (PRF) –

- allocates an additional \$3 billion in resources for the PRF;
- requires that 85 percent of currently unobligated funds in the Provider Relief Fund are allocated equitably via applications that consider financial losses and changes in operating expenses;
- provides clarification that PRF payments made prior to September 19, 2020, must be calculated using the Frequently Asked Question guidance released by HHS on June 19, 2020; and
- allows additional flexibility for providers by clarifying that eligible health-care providers may transfer all or any portion of such payments among the subsidiary eligible health-care providers of the parent organization.

More information:

<https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/OMNISurpriseBillingPublicHealthFDFINAL3.pdf>

Paycheck Protection Program (PPP) –

- The act creates the PPP Second Draw Loan (SDL) program, for smaller and harder-hit businesses, which can borrow a maximum of \$2 million. Applicants must demonstrate at least a 25-percent

reduction in gross receipts when comparing any quarter of 2020 to the same quarter of 2019 (there are applicable timelines for businesses not in operation during 2019 to use). The PPP SDLs are fully forgivable, provided the funds are used for eligible payroll and non-payroll expenses and the spending meets the previous 60/40 allocation between payroll and non-payroll expenses.

- The act removed the previous requirement to deduct the EIDL Advance from the total PPP forgivable amount.
- The act clarifies the tax treatment for PPP loans, specifically that gross income doesn't include any forgiven portion of the PPP loan and deductions are allowed for otherwise deductible business expenses when paid using PPP funds that are forgiven.
- The act provides a simplified forgiveness application for loans of \$150,000 or less.

More information: www.apma.org/COVID19SBA

Surprise Medical Billing

Among a host of public health, diabetes programs, consumer protections, drug pricing, pharmacy benefits, and other provisions, here's a summary of the Surprise Billing provisions our members will be most interested in:

- **Hold Patient's Harmless:** Health plans must hold patients harmless from surprise medical bills. Patients will only be required to pay the in-network cost-sharing (i.e., co-payment, coinsurance and deductibles) amount for out-of-network emergency care, for certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patients informed consent. Patients in-network cost sharing payments for out-of-network services must also be attributable to the patients in-network deductible.
- **Determining Out-of-Network Rates, IDR Process:** Provides a 30-day open negotiation period for providers and payors to settle out-of-network claims. If unable to settle, the parties may access binding arbitration – referred to as Independent Dispute Resolution (IDR). IDR process will be administered by independent third parties with no affiliation to providers or payors. IDR will consider the market-based median in-network rate, alongside relevant information brought by either party, information requested by the reviewer, as well as factors such as the provider's training and experience, patient acuity and the complexity of furnishing the item or service, in the case of a provider that is a facility, the teaching status, case mix and scope of services of such facility, demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement, prior contracted rates during the previous four plan years, and other items. Billed charges and public payer rates are excluded from consideration. Following IDR, the party that initiated the IDR may not take the same party to IDR for the same item or service for 90 days following a determination by the IDR entity, in order to encourage settlement of similar claims, but all claims that occur during that 90-day period may still be eligible for IDR upon completion of the 90-day period.

- Provider Requirements: Prohibits providers and payors from sending out-of-network bills to patients for amounts greater than the in-network cost-sharing amount. Also prohibits certain out-of-network providers from surprise billing patients unless the provider gives the patient notice of 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. For appointments made within 72 hours of receiving services, the patient must receive notice the day the appointment is made and consent to receive out-of-network care.
 - Providers and facilities will also be required to verify, three days in advance of service and not later than one day after scheduling such service, what type of coverage the patient is enrolled in, and a good faith estimate for the services requested.
 - Continuity of Care: if a provider changes network status, patients with complex care needs have up to a 90-day period of in-network cost sharing
- Transparency in Health Plans: individual and group health plans will be required to disclose the amount of the in-network and out-of-network deductibles, and the in-network and out-of-network out-of-pocket maximum limitations.
- Price Comparison: Health plans will be required to provide a price comparison tool for consumers.
- Provider Directory: Health plans will be required to maintain up-to-date online directories of their in-network providers. If a patient documents that they received incorrect information from a plan about a provider's in-network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount.
- Non-discrimination: requires the Secretaries of HHS, Labor, and Treasury to promulgate regulations no later than January 1, 2022 implementing protections against provider discrimination.
- Plan Transparency:
 - Gag clauses: bans gag clauses from contracts between providers and health plans which prevent everyone from seeing cost and quality data on providers. Also bans gag clauses from contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared, under HIPAA, with third parties for plan administration and quality improvement purposes.
 - Broker/Consultant Compensation: requires health benefit brokers and consultants to disclose to plan sponsors any direct or indirect compensation that brokers or consultants may receive for referrals.

More Information:

<https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/OMNISurpriseBillingPublicHealthFDAFINAL3.pdf>