REGULATORY

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Consolidated Appropriations Act of 2021

December 21, 2020

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The Consolidated Appropriations Act of 2021 (5,593 pages), was released the afternoon of December 21, specifically the provisions relating to "Surprise Medical Billing" (SMB) and other key healthcare provisions of the pending law at this time. The bill was passed by the House and Senate yesterday (12/21/20) and is expected to be signed by the President.

Specific details on the specialty impacts on changes to the 2021 Medicare Physician Fee Schedule (PFS) are not presently known, as the entirety of the PFS will have to be recalibrated with new values based on this bill. More information on the PFS will be forthcoming as we determine the details—more is known on the specifics of SMB, which will take effect on 1/1/22. The No Surprises Act (NSA) "2.0," (version 2.0, released on 12/20/20 versus the "1.0" version issued on 12/11/20) was revised positively in several aspects as highlighted below.

Below are Key Components of the Legislation Related to Healthcare

2021 Medicare Physician Fee Schedule (MPFS):

- Provides for a one-time, one-year increase in the Medicare physician fee schedule of 3.75 percent, in order 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.
- The bill would delay for 3 years the Secretary's implementation of Code G2211 (formerly GPC1X) which reportedly will increase the MPFS by approximately 3 percent. While details have not been released, we understand that these provisions will impact the entirety of the '21 MPFS as the "practice expense" RVUs will change.

Sequestration Cuts delayed:

- The bill would delay the -2% sequestration cuts for 3 months to permit the new Congress to address these in 2021.

Extend GCPI Floor:

- The bill would extend the "GPCI floor" of 1.0 through December 31, 2023

Payment and patient count thresholds for eligible clinicians participating in APMs:

The bill would also temporarily freeze payment and patient count thresholds for eligible clinicians participating in APMs to receive the +5% incentive for performance years '21 and '22, and payable in in '23 and '24, respectively.

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Consumer Protections against Surprise Medical Bills (SMB):

The legislation takes effect on January 1, 2022 and protects patients against surprise medical bills and establishes a process for resolving out-of-network bill disputes between providers and patients. Specifically, it:

- Takes patients out of the middle of billing disputes by banning balance billing nationwide (unless there is notice and consent for scheduled care) and sets up federal procedures for handling billing disputes (unless state law addresses appropriate reimbursement for that claim) The new federal SMB law will apply to ERISA plans even in states that have an established SMB solution, (e.g., NY, TX and GA).
- Holds patients harmless from surprise medical bills. Patients are only required to pay the in-network cost-sharing, (i.e., copayment, 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 patient's informed consent.
- Determination of out-of-network rates to be paid by health plans via Independent Dispute Resolution (IDR) process. Provides for a 30-day open negotiation period for providers and payers to settle out-of-network claims. It also states that if the parties are unable to reach a negotiated agreement, they may access a binding arbitration process (IDR), in which one offer prevails. Providers may batch similar services in one proceeding when claims are from the same payer, but the bill was changed to permit only 30 days of batching. The IDR process will be administered by independent, unbiased entities with no affiliation to providers or payers. The IDR entity is required to 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. Neither provider charges nor government payor rates may be considered by the adjudicator in the IDR by law.
- Elimination of the requirement that the patients receive a detailed description of services rendered within 15 days of the date of service and elimination of the requirement that if the patient is not billed within 90 days of the date of service the patient cannot be held responsible.
- Providers sought but did not obtain a provision that the health plan's initial payment for services would be their "final offer" to be evaluated by the adjudicator in IDR, to bar against health plans making unreasonably low initial payments.

- Holds patients harmless from surprise air ambulance medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances, and that cost-sharing amount is applied to their in-network deductible. Air ambulances are barred from sending patients surprise bills for more than the in-network cost-sharing amount.
- Requires health plans to provide 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
- Improves the accuracy of provider directories by holding plans and providers accountable for inaccurate directories, ensuring patients have more up-to-date information and are responsible for only their in-network cost-sharing amount when they rely on an inaccurate provider directory.

Improves Transparency in Healthcare:

The legislation makes several changes to increase transparency in healthcare. Specifically, it:

- Bans gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers.
- Requires health benefit brokers and consultants to disclose to group health plan sponsors any direct or indirect compensation the brokers and consultants may receive for referral of services. Extends similar protections to consumers with respect to individual market coverage and short-term, limited duration insurance.
- Requires health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor, and the Treasury. Requires online publication of a report on prescription drug pricing trends and the contribution to health insurance premiums 18 months after the date of enactment, and every two years thereafter.
- Requires the public reporting of hospice survey results on the CMS' website to help inform patients and families.

Paycheck Protection Program (PPP):

Congress authorized an additional $284B for the PPP, which would be added to the $138B remaining in the PPP program.

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Provider Support Relief Fund Payments:

The legislation provides additional relief to health care providers, including making additional investments in the Provider Relief Fund and clarifying policies related to certain aspects of the program. Specifically, it:

- Invests $3 billion in new resources for the Provider Relief Fund, in addition to existing funds.
- Provider organizations were successful in advocating that the Tranche 3 PRF should not be artificially limited as Tranche 1 and 2 payments were to the 2% of the provider's gross receipts from 2019. So, in Tranche 3, HHS announced that they were targeting PRF payments to 88% of the provider's lost revenues and increased expenses for the first 6 months of 2020.
- Ensures 85 percent of the monies currently unobligated in the Provider Relief Fund are allocated equitably via applications that considers financial losses and changes in operating expenses.

Medicare Payment for Rural Hospital Emergency Services:

- The bill creates a new voluntary Medicare designation that permits critical access hospitals (CAHs) and small hospitals less than 50 beds to convert to a "Rural Emergency Hospital" (REH) designation.
- REH may furnish observation services, outpatient services, telehealth, ambulance and SNF services and receive Medicare prospective payment, plus an additional facility fee and an add on reimbursement for outpatient services.

Delay Start of Radiation Oncology Model

Congress voted to delay the start date of the CMS radiation oncology model demonstration until January 1, 2022, six months beyond what CMS proposed in the Final Rule issued on December 2, but in line with what stakeholders had requested.