**Selected Provisions from the omnibus legislation signed by the President on December 27, 2020. Contents include highlights of importance to academic family medicine including: Medicare GME changes, COVID-relief, and the appropriations spending bills.**

**Sec. 113. Moratorium on payment under the Medicare physician fee schedule**

**of the add on code for inherently complex evaluation and management**

**visits.**

The Secretary of Health and Human Services may not, prior to January 1, 2024, make payment under the fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for services described by Healthcare Common Procedure Coding System (HCPCS) code G2211 (or any successor or substantially similar code),

**Sec. 126. Distribution of additional residency positions.**

This is partially similar to the historic 15,000 slot bills that AAMC has supported since the ACA, but much smaller and with several changes. It allows for 1,000 total new slots, with no more than 200 slots per year.

First eligibility criteria: The Secretary shall take into account the demonstrated likelihood of the hospital filling the positions

Not less than 10% for **each** of the following categories:

1. Hospitals in rural areas (1886(d)(2)(D)) or treated like a rural area (section 1886(d)(8)(E).[[1]](#footnote-1)
2. Over cap hospitals - Hospitals in which the reference resident level of the hospital (as specified in subparagraph (F)(iii)) is greater than the otherwise applicable resident limit.
3. Hospitals in states with new medical schools, and branch campuses, etc.
4. Hospitals that serve areas designated as health professional shortage areas under section 332(a)(1)(A) of the Public Health Service Act, as determined by the Secretary.

(Note: While better in that it has minimum distributions, especially rural and shortage areas, 60% of the slots are not tied to any priority. They can go anywhere.

Additional provisions include:

* No more than 25 new positions per hospital
* Must have agreement to increase by number given
* PRA will be equal to primary care and non-primary care rates for that hospital.
* After five years, these spots can be used by other hospitals within an affiliated group, not just the hospital that applied for them.
* Calls for a GAO Study (see below for particulars.)

Note: no primary care mandate for new positions or maintenance of old positions.

The Comptroller General of the United States (in this subsection referred to as the ‘‘Comptroller General’’) shall conduct studies, and report on later than September 30, 2025 and then 2027 on:

(A) the distribution of additional full-time equivalent resident positions; and

(B) rural track and rotator programs under such section.

The report must contain: a description of the distribution of the additional positions and an analysis of the use of such positions, including a description of the effects of such distribution on rural track and rotator programs;

(B) a specification, with respect to each hospital that has received such a distribution, of whether such hospital has abided by the agreement described in paragraph (9)(C)(ii) of section 1886(h) of the Social Security Act, as added by subsection (a); and (C) to the extent practicable, a description of—

1. the type of program in which each such position so distributed is being used;
2. the total number of full-time equivalent residency positions available in each such program;
3. the number of instances in which residents filling such positions so distributed treated individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);
4. the location where each resident that filled a position so distributed went on to practice.

**Sec. 127. Promoting Rural Hospital GME Funding Opportunity.**

New language from Wenstrup and Sewell included. This is language we worked on several weeks ago – it is supposed to remove the rolling average and support the growth of resident caps in rural tracks, including the urban locations. The bill language is not very helpful (at least to me) in determining whether it does so or not. If it is true, it is a partial win for us. When working with Rep. Wenstrup’s office we made it clear that it did not address several issues regarding RTTs that we are interested in, but they were moving very fast and didn’t want to include additional material. Wenstrup’s staffer agreed to discuss these further with the possibility of addressing some of them in the next Congress.

**Sec. 131. Medicare GME treatment of hospitals establishing new medical residency**

**training programs after hosting medical resident rotators**

**for short durations.**

This is a big win for us. The Rural Rotator bill as we have called it, was included in the BETTER Act in a Ways and Means markup last year. That language is now included in this bill. It allows for “rebasing” caps that were set at below 1.0 FTE in 1997 (based on 1996 cost reports,) no more than 3.0 FTEs in the intervening years prior to enactment of this bill, and ensures that no hospital will be determined to be a teaching hospital unless/until it trains more than 1.0 FTE in a fiscal year. PRAs for these hospitals will also be allowed to be rebased. However, these are one-time opportunities and must occur within a 5 year window following enactment of the bill.

**A separate discussion draft contains several other (non-Medicare) private health and public health insurance provisions that we have been working on as well as many that aren’t included as AFMAC priorities, but which are of interest to our members/organizations.**

THCGME – THC’s are reauthorized at the current level of $126.5 million through fiscal year 2023. Since we are half-way through FY2021, the reauthorization is not the four or five year reauthorization that was in the House and Senate bills.

NHSC – Similar to THC’s the National Health Service Corps was reauthorized with mandatory funding at current levels ($310 million) through FY2023.

CHCs – Community health centers were also reauthorized at current levels ($4 billion) through FY2023.

**No Surprises Act**

There is an entire title devoted to Surprise billing including provisions dealing with the following:

Sec. 102. Health insurance requirements regarding surprise medical billing.

Sec. 103. Determination of out-of-network rates to be paid by health plans;

Independent dispute resolution process.

Sec. 104. Health care provider requirements regarding surprise medical billing.

Sec. 105. Ending surprise air ambulance bills.

Sec. 106. Reporting requirements regarding air ambulance services.

Sec. 107. Transparency regarding in-network and out-of-network deductibles

and out-of-pocket limitations.

Sec. 108. Implementing protections against provider discrimination.

Sec. 109. Reports.

Sec. 110. Consumer protections through application of health plan external review

in cases of certain surprise medical bills.

Sec. 111. Consumer protections through health plan requirement for fair and

honest advance cost estimate.

Sec. 112. Patient protections through transparency and patient-provider dispute

resolution.

Sec. 113. Ensuring continuity of care.

Sec. 114. Maintenance of price comparison tool.

Sec. 115. State All Payer Claims Databases.

Sec. 116. Protecting patients and improving the accuracy of provider directory

information.

Sec. 117. Advisory committee on ground ambulance and patient billing.

Sec. 118. Implementation funding.

**‘‘SEC. 735. STANDARDIZED REPORTING FORMAT, and establishment of a new advisory committee.**

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Within a year the Secretary shall establish and periodically update a standardized reporting format for the voluntary reporting, by group health plans to state all payer claims databases, of medical, pharmacy, and dental claims and the eligibility and provider files that are collected. It also establishes an Advisory Committee of 15 members to advise the Secretary. Members shall include those who have distinguished themselves in the fields of health services research, health economics, health informatics, data privacy and security, or the governance of State All Payer Claims Databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations that sponsor group health plans, health care providers, health insurance issuers, or third party administrators of group health plans.

**‘‘SEC. 2799A–7. OTHER PATIENT PROTECTIONS.**

CHOICE OF HEALTH CARE PROFESSIONAL: if a group plan or health insurer provides or requires the designation of a primary care participating provider, then the beneficiary may designate any participating provider who is available.

**Continuing Resolution – Appropriations for FY2021**

* Title VII primary care training and enhancement – current levels (47.9 million)
* Rural Residency Development Program – Funded at $5 million, which is a decrease of half from current, FY2020 levels and down from the $11 million that was in the House bill.
* NIH $42.9 billion, up $1.25 billion (3 percent.) This includes an additional $55 million for the NIMHD to address disparities.
* AHECs, up $2 million, to $43.25 million
* AHRQ, $338 million (plus tap from PCOR trust fund) which is current levels – a win since the Senate had a cut of $82 million.
* Midwife training - $2.5 million to train midwives due to shortage and lack of diversity of the maternity care workforce.
* CDC - $7.8 billion, including $1.28 b for Chronic Diseases and Health Promotion

Also included is an interesting provision for CMS related to rural hospitals:

*Rural Hospitals*.-The agreement directs CMS to study and propose

solutions that would allow vulnerable hospitals serving rural and underserved populations to receive relief in the near-term, as well as explore payment options that can ensure that more hospitals serving rural and underserved populations can operate in a more financially sustainable way. These recommendations should be provided to the Committees on Appropriations, the Senate Committee on Finance, and the Committees on Ways and Means and Energy and Commerce of the House of Representatives within 180 days of enactment of this Act.

**COVID-relief bill highlights include:**

$284.45 billion for PPP, with set-asides (eg $35 billion for first-time borrowers, $15 billion of which for smaller, first-time borrowers with 10 or fewer employees, or loans less than $250,000 in low-income areas; $25 billion for second draw PPP loans for smaller borrowers with 10 or fewer employees, or loans less than $250,000 in low-income areas.

Healthcare related provisions include:

* **Department of Health and Human Services –** $73 billion to support public health; research, development, manufacturing, procurement, and distribution of vaccines and therapeutics; diagnostic testing and contact tracing; mental health and substance abuse prevention and treatment services; child care support; and other activities related to coronavirus, including:
* Centers for Disease Control (CDC) $8.75 b for distribution to public health agencies
* Public Health and Social Services Emergency Fund: $25.4 billion to support testing and contact tracing to effectively monitor and suppress COVID-19, as well as to reimburse for health care related expenses or lost revenue attributable to the coronavirus, including:
* $3 billion in additional grants for hospital and health care providers to be reimbursed for health care related expenses or lost revenue directly attributable to the public health emergency resulting from coronavirus, along with direction to allocate not less than 85 percent of unobligated funds in the Provider Relief Fund through an application-based portal to reimburse health care providers for financial losses incurred in 2020.
* National Institutes of Health – $1.25 billion to support research and clinical trials related to the long-term effects of COVID-19, as well as continued support for Rapid Acceleration of Diagnostics for COVID-19.
* Substance Abuse and Mental Health Services Administration – $4.25 billion to provide increased mental health and substance abuse services and support, including:
* Sec. 101. Supporting Physicians and Other Professionals In Adjusting to Medicare Payment Changes During 2021: 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.
* Sec. 102. Extension of Temporary Suspension of Medicare Sequestration: Provides for a three-month delay of the Medicare sequester payment reductions through March 31, 2021.
1. (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify. [↑](#footnote-ref-1)