

## Coronavirus Relief & Omnibus Agreement

The Coronavirus Relief & Omnibus Agreement provides long overdue funding dedicated to fighting COVID and supporting providers and patients during the pandemic, and also makes critical investments in Medicare, Medicaid, and the public health infrastructure.

**Public Health Investments to Crush COVID-19.** The legislation invests in public health systems to expand access to vaccines, testing, personal protective equipment (PPE), and mental health services. Specifically, it:

- Invests \$22.4 billion in testing, contact tracing, surveillance, containment, and mitigation, with a targeted investment of no less than \$2.5 billion for expanding access to testing and contact tracing in high-risk and underserved populations, including for communities of color and rural areas, and \$790 million for the Indian Health Service to support Tribes.
- Dedicates over \$19 billion in the nation's supply of COVID-19 vaccines and therapeutics, including the manufacture, production, and purchase of vaccines, therapeutics, and ancillary supplies.
- Supplies \$8.75 billion for vaccine distribution, administration, planning, preparation, promotion, monitoring, and tracking, with a targeted investment of \$300 million for high-risk and underserved populations, including for communities of color and rural areas, and \$210 million for the Indian Health Service to distribute vaccines directly to Tribes.
- Reinforces our Strategic National Stockpile with an investment of \$3.25 billion.
- Supports \$4.25 billion in investments for additional mental health and substance use disorder services and support through the Substance Abuse and Mental Health Services Administration.
- Provides long-term extensions of critical public health programs, including: Community Health Centers, the National Health Service Corps, Teaching Health Centers, and Special Diabetes Programs.
- Authorizes a national campaign to increase awareness and knowledge of the safety and effectiveness of vaccines, expands programs to collect vaccination coverage data, and authorizes grants to address vaccine-preventable diseases.
- Creates a grant program to expand the use of technology-enabled collaborative learning and capacity-building models to increase access to specialized health care services in medically underserved areas and for medically underserved populations.
- Expands, enhances, and improves public health data systems at the Centers for Disease Control and Prevention (CDC) and authorizes grants to state, local, Tribal, or territorial public health departments for the modernization of public health data systems. These investments will improve disease and health condition detection, improve secure public health data collection, enhance interoperability, and support and train personnel.
- Reauthorizes the School Based Health Center Program.

**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.

- 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.
- Provides additional certainty to providers by clarifying that payments made prior to September 19, 2020, must be calculated using the Frequently Asked Question guidance released by HHS on June 19, 2020.
- 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.
- Provides for a three-month delay of the Medicare sequester payment reductions through March 31, 2021.
- 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.

**Medicare Beneficiary Investments.** The legislation makes important, overdue investments for Medicare to support access to health care for beneficiaries. Specifically, it:

- Simplifies and accelerates Medicare enrollment by mandating that Part B insurance begin the first of the month following an individual's enrollment during both the later months of the beneficiary's Initial Enrollment Period (IEP) and during the General Enrollment Period (GEP).
- Allows the federal government to create a Part A and B Special Enrollment Period (SEP) for exceptional circumstances like natural disasters.
- Extends funding for programs that help Medicare-eligible individuals and their families and caregivers determine the best way to access affordable, comprehensive health care.
- Lowers beneficiary costs by phasing in a waiver of coinsurance for certain colorectal cancer screening tests.
- Improves quality and safety in Medicare by: 1) extending funding for the National Quality Forum for an additional three years, 2) improving the Skilled Nursing Facility Value-Based Purchasing Program, 3) extending and expanding two demonstration programs that improve quality of care for vulnerable populations, 4) encouraging access to Alzheimer's screening through physician education, and 5) providing intermediate remedies to improve quality in poor-performing hospices.
- Improves access to mental health care by permanently expanding Medicare coverage of mental health telehealth services.
- Provides eligibility for immunosuppressive drug coverage through Medicare to individuals post-kidney transplant who do not receive coverage through other insurance.
- Helps seniors and other individuals with the high cost of medical care by permanently lowering the Medicare Expense Deduction threshold to 7.5 percent of gross income.

**Workforce Investments.** The legislation makes long-needed investments in physician training, encourages more opportunities for physician training in rural settings, and expands access through greater flexibility for physician assistants. Specifically, it:

- Adds 1,000 new Medicare-funded graduate medical education (GME) full-time equivalent (FTE) residency positions, beginning in fiscal year 2023, which will be available to the following groups: 1) rural hospitals and hospitals treated as rural hospitals; 2) hospitals over their otherwise applicable resident limit; 3) hospitals in states with certain new medical schools and medical schools with additional locations and branch campuses; and 4) hospitals that serve Health Professional Shortage Areas (HPSAs).
- Helps beneficiaries receive better access to care and supports improvements in workforce competency by:
  - Allowing physician assistants to bill Medicare directly to increase access.
  - Allowing hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent FTE resident cap or Per Resident Amount.
  - Encouraging the expansion of rural training opportunities through Medicare GME Rural Training Track programs.

**Rural Health Investments.** The legislation makes a number of changes to Medicare to support providers and access to care in rural communities. Specifically, it:

- Maintains access to rural emergency and other outpatient services by allowing rural hospitals that are struggling to support inpatient capacity to convert to a new Rural Emergency Hospital (REH) designation.
- Allows Federally Qualified Health Center and Rural Health Clinic (RHC) physicians to provide hospice attending physician services for their patients if they elect the hospice benefit.
- Supports low-population communities in maintaining access to hospital services through Extends the Frontier Community Health Integration Project and Rural Community Hospital Demonstration to continue allowing certain rural hospitals to test new ways of paying for and delivering care in rural areas.
- Increases Medicare payments to RHCs that are subject to a payment cap by phasing-in an increase in payment.
- Extends a provision that ensures Medicare physician payments reflect the local costs of providing care, adjusted for differences in market conditions and business costs.

**Consumer Protections against Surprise Medical Bills.** The legislation protects patients against surprise medical bills and establishes a fair process for resolving out-of-network bill disputes between providers and patients. Specifically, it:

- 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.
- 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.

- Allows consumers to access an external review process to determine whether surprise billing protections are applicable when there is an adverse determination by a health plan.
- 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
- Allows patients with complex care needs to have up to a 90-day period of continued coverage at in-network cost-sharing to allow for a transition of care to an in-network provider.
- 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 Health Care.** The legislation makes a number of changes to increase transparency in health care. 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 Centers for Medicare & Medicaid Services' website to help inform patients and families.

**Medicaid Enhancements.** The legislation restores Medicaid eligibility to citizens of the Freely Associated States, strengthens Medicaid beneficiary protections, enhances mandatory Medicaid benefits, and extends a number of expiring Medicaid programs. Specifically, it:

- Restores Medicaid eligibility for citizens of the Freely Associated States, sometimes referred to as Compacts of Free Association (COFA) migrants, who are legally residing in the United States.
- Requires state Medicaid programs to cover non-emergency medical transportation (NEMT) to ensure that beneficiaries who lack access to regular transportation are able to travel to their medical appointments.
- Enhances protections for beneficiaries receiving home- and community-based services (HCBS) by authorizing Medicaid Fraud Control Units (MFCUs) to investigate fraud and abuse in non-institutional settings.

- Extends protections against spousal impoverishment for partners of recipients of HCBS for three years.
- Extends funding for the Money Follows the Person rebalancing demonstration for an additional three years while making important program improvements.
- Extends the demonstration to expand access to certified community behavioral health clinics until fiscal year 2024.
- Requires state Medicaid programs to pay for the cost of services provided as part of a beneficiary’s participation in a clinical trial for drugs to treat serious and life-threatening conditions.

**Prescription Drug Improvements.** The legislation includes a number of necessary prescription drug reforms to improve transparency and reporting and to improve beneficiaries’ access to coverage. Specifically, it:

- Requires all manufacturers of drugs covered by Medicare Part B to report average sales price (ASP) data to the Secretary of the Department of Health and Human Services, as is currently done in Medicaid.
- Allows the Secretary of HHS to exclude from Medicare payment the costs of certain drugs that are not covered under Part B when they are self-administered.
- Makes permanent a program that provides temporary Part D coverage to Medicare beneficiaries who are not currently enrolled in a prescription drug plan (PDP) and meet certain income-related eligibility criteria.
- Gives doctors and Medicare beneficiaries information about how much a patient will pay for a drug while they are in the doctor’s office by requiring Medicare Part D plans to use a “real-time benefit tool.”
- Gives MedPAC and the Medicaid and CHIP Payment and Access Commission access to important drug pricing and rebate data to facilitate analyses to inform Congress on drug policy.

**Mental Health Parity.** The legislation includes provisions that improve and strengthen enforcement of existing mental health parity laws and increase transparency with respect to how health plans are applying mental health parity laws. It requires group health plans and health 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. Specifically, it:

- Requires the Secretaries of Labor, HHS, 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 the Secretaries determine appropriate.
- If, upon review of the analyses, the Secretaries of Labor, HHS, and the Treasury find that a plan or coverage offered by an issuer is out of compliance with mental health parity law, the Secretary must specify corrective actions for the plan or coverage to come into compliance, which the plan will have 45 days to implement.
- Requires the Secretaries of Labor, HHS, and the Treasury to publish an annual report with a summary of the comparative analyses.