

Consolidated Appropriations Act, 2021 (H.R. 133) Summary

Information for Neurosurgeons

On Dec. 27, 2020, President **Donald J. Trump** signed the Consolidated Appropriations Act, 2021 ([H.R. 133](#)) into law (P.L. 116-260) — a massive omnibus spending bill that includes nearly \$900 billion for coronavirus relief and an additional \$1.4 trillion spending package to fund the federal government through the end of the Fiscal Year 2021. The measure incorporates several priorities of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS). Provisions of interest to neurosurgeons are detailed below.

Medicare Payment Provisions

Background

Substantial changes in how neurosurgeons report office and outpatient evaluation and management (E/M) clinic visits were implemented beginning on Jan. 1, 2021. Under [the new system](#), CPT code 99201 was eliminated, and changes were made to the remaining codes for new patient visits (CPT codes 99202 to 99205) and established patient visits (CPT codes 99211 to 99215) — including the values of each code. Unfortunately, despite nearly uniform agreement among the medical community, CMS refused to adjust the E/M portion of the 10- and 90-day global surgery codes to account for the increased values of the stand-alone E/M codes. Thus, the value of neurosurgical procedures will not increase. Furthermore, CMS proposed a new add-on code — G2211 (formerly GPC1X) — for complexity inherent to E/M services that will commonly be reported only by specific subspecialties, not including neurosurgery.

Because E/M services represent about 40% of the entire Medicare physician fee schedule (MPFS), even small changes in the E/M values significantly impact all provider payments. By law, any MPFS changes cannot increase or decrease Medicare expenditures, and to comply with this budget neutrality requirement, any increases must be offset by corresponding decreases. CMS estimated that the 2021 policies would increase Medicare spending by approximately \$10.6 billion, **necessitating steep cuts for many specialties, including an overall 6-7% payment cut for neurosurgery.**

Facing double-digit Medicare payment cuts in 2021 and beyond, and recognizing that reductions of this magnitude could lead to reduced access to care for Americans, on June 18, 2020, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) — with significant funding support from the Council of State Neurosurgical Societies (CSNS) and the Section on Disorders of the Spine and Peripheral Nerves — along with 10 other national surgical associations, founded the [Surgical Care Coalition](#) (SCC). The SCC launched a targeted, multi-faceted advocacy and public relations campaign to prevent these cuts. Specifically, the SCC advocated that Congress adopt legislation that would:

- Increase the global surgery code values;
- Halt implementation of the G2211 add-on code for complex E/M visits; and
- Prevent any additional cuts resulting from the new E/M payment policies.

Working with the SCC and other physician and allied health professional organizations, the AANS and the CNS successfully advocated for legislation to prevent these cuts, as the Consolidated Appropriations Act, 2021 incorporated several of our proposed policy options.



American
Association of
Neurological
Surgeons



AANS/CNS Washington
Committee for
Neurological Surgery



Congress of
Neurological
Surgeons

Physician Payment Adjustments and E/M Changes

- ❖ **Mitigates budget neutrality cuts to physician payments.** The legislation mitigates the 10.2% across-the-board reduction due to budget neutrality requirements in two ways:
 - A **3.75 percent increase** in the MPFS for 2021. (Div. N, Sec. 101)
 - **Suspending code G2211** for three years, through December 2023. (Div. CC, Sec. 113)

Based on an AMA [impact table](#), the combination of these two policies will significantly reduce the budget neutrality adjustment. Overall, **neurosurgeons should not experience any Medicare payment cuts** (although the specific impact will depend on the mix of services provided) in 2021. In implementing the new law, CMS has adjusted the 2021 MPFS. [Click here](#) for the updated Addendum B, which includes the relative value units for all services. The 2021 conversion factor is now \$34.8931 rather than \$32.4085, although still shy of the 2020 CF of \$36.0896.

The following chart includes a handful of examples of services provided by neurosurgeons (non-E/M services are facility rates; E/M services are non-facility rates):

CPT Code	Descriptor	2020 MPFS National Fee	2021 MPFS National Fee (12/1/20 Final Rule)	2021 MPFS National Fee (12/29/20 Adjusted)
22551	Anterior cervical discectomy and fusion	\$1,782.10	\$1637.28	\$1,752.68
22558	Anterior lumbar interbody fusion	\$1,602.02	\$1,469.08	\$1,574.38
22600	Posterior cervical fusion	\$1,345.78	\$1,248.38	\$1,335.01
22612	Posterior lumbar fusion	\$1,660.12	\$1,523.85	\$1,633.69
22630	Posterior lumbar interbody fusion	\$1,645.32	\$1,520.61	\$1,625.67
22633	Lumbar spine fusion combined	\$1,936.93	\$1,777.93	\$1,905.16
35301	Carotid endarterectomy	\$1,187.35	\$1,075.31	\$1,150.77
36224	Carotid angiography	\$376.41	\$343.85	\$368.12
61312	Crani for EDH/SHD	\$2,164.29	\$1,995.39	\$2,130.92
61510	Crani for tumor	\$2,286.64	\$2,118.87	\$2,261.07
61512	Crani for tumor, meningioma	\$2,664.13	\$2,457.86	\$2,623.96
61645	Mechanical thrombectomy	\$873.01	\$797.90	\$854.18
61697	Complex intracranial aneurysm	\$4,427.11	\$4,034.86	\$4,311.39
61798	Stereotactic radiosurgery, 1 complex lesion	\$1,436.37	\$1,329.72	\$1,418.75
61867	DBS with microelectrode recording	\$2,378.67	\$2,196.00	\$2,344.82
62223	VP shunt	\$1,083.41	\$1,003.69	\$1,071.57
63030	Lumbar discectomy	\$1,014.48	\$938.87	\$1,005.27
63042	Re-do lumbar discectomy	\$1,354.80	\$1,243.51	\$1,333.61
63045	Cervical laminectomy	\$1,342.17	\$1,239.63	\$1,326.29
63047	Lumbar laminectomy	\$1,151.26	\$1,063.65	\$1,138.56
63655	Laminectomy for placement of DCS electrode	\$866.51	\$806.32	\$861.51

CPT Code	Descriptor	2020 MPFS National Fee	2021 MPFS National Fee (12/1/20 Final Rule)	2021 MPFS National Fee (12/29/20 Adjusted)
64718	Ulnar Nerve Transposition	\$618.58	\$575.57	\$617.61
64721	Carpal tunnel surgery	\$446.43	\$417.10	\$447.68
99203	Office/outpatient visit, new low/30-44 min	\$109.35	\$106.30	\$113.75
99204	Office/outpatient visit, new mod/45-59 min	\$167.09	\$159.77	\$169.93
99205	Office/outpatient visit, new high/60-74 min	\$211.12	\$210.98	\$224.36
99213	Office/outpatient, established low/20-29 min	\$76.15	\$86.85	\$92.47
99214	Office/outpatient, established mod/30-39 min	\$110.43	\$123.48	\$131.20
99215	Office/outpatient, established high/40-54 min	\$148.33	\$172.74	\$183.19

- ❖ **Extends the suspension of the 2% Medicare sequestration.** (Div. N, Sec. 102) Initially set to end on Dec. 31, 2020, the Medicare sequestration cut is pushed out and is now scheduled to end on March 31, 2021. This means the two percent cut to Medicare payments is avoided for three months, which will provide a temporary reprieve from these additional Medicare cuts.
- ❖ **Increases payments for the work component** of the MPFS in areas where labor cost is determined to be lower than the national average through Dec. 31, 2023. (Div. CC, Sec. 114)
- ❖ **Temporarily freezes APM payment incentive thresholds.** (Div. CC, Sec. 114) The legislation freezes for two years the thresholds to qualify for the incentive payments for participating in Alternative Payment Models (APM) at their current levels. This should allow more physicians to qualify for the 5% APM incentive payment for 2023 and 2024 and avoid disqualification from failing to meet the standard.
- ❖ **Encourages the assessment of evaluation and management services.** (Div. HH; Title II) The agreement notes CMS's efforts to ensure appropriate valuation of services under the MPFS. The agreement encourages CMS to assess the effects of any changes on access to services and workforce incentives.

Miscellaneous Medicare, Medicaid and Public Health Provisions

Medicare

- ❖ **Provides funding for quality measure endorsement**, input and selection. (Div. CC; Sec. 102). The legislation includes an additional \$66 million to CMS for quality measure selection to October 1, 2023.
- ❖ **Permits direct payment to physician assistants under Medicare.** (Div. CC; Sec. 403.) This section allows direct payment under the Medicare program to physician assistants for services furnished to beneficiaries before Jan. 1, 2022.

Medicaid

- ❖ **Eliminates disproportionate share hospital reductions** for fiscal years 2021 through 2023. (Div. CC; Sec. 201)
- ❖ **Promotes access to life-saving therapies for Medicaid enrollees** by ensuring coverage of routine patient costs for items and services furnished in connection with participation in qualifying clinical trials. (Div. CC; Sec. 210)

Public Health

- ❖ **Supports the Interagency Task Force on Trauma-Informed Care.** (Div. H; Title II) The agreement supports the Task Force's authorized activities, including the dissemination of trauma-informed best practices and the promotion of such models and training strategies through all relevant grant programs.
- ❖ **Expands capacity for health outcomes.** (Div. CC; Sec. 313) Grants will be awarded to eligible entities to evaluate, develop, and, as appropriate, expand the use of technology-enabled collaborative learning and capacity building models.
- ❖ **Modernizes public health data systems.** (Div. CC; Sec 314) Requires HHS to expand, enhance, and improve public health data systems used by the Centers for Disease Control and Prevention (CDC). It also requires HHS to award grants to State, local, Tribal, or territorial public health departments to modernize public health data systems.
- ❖ **Extends rare pediatric disease priority review.** (Div. CC; Sec. 321) Allows FDA to continue to award priority review vouchers for drugs that treat rare pediatric diseases and are designated no later than Sept. 30, 2024, and approved no later than Sept. 30, 2026.
- ❖ **Funds firearm injury and mortality prevention research.** Provides \$12.5 million to the CDC, the same amount as the 2020 enacted level, to specifically support firearm injury and mortality. None of the funds may be used, in whole or in part, to advocate or promote gun control. (Div. H; Sec. 210)
- ❖ **Provides funds for a firearms background check system.** (Division B; Title II) Provides \$85 million for grants to states to upgrade criminal and mental health records for the National Instant Criminal Background System (NICS).
- ❖ **Funds heart disease and stroke prevention.** (Div. H; Title II) The agreement includes \$143,105,000 to strengthen and expand evidence-based heart disease and stroke prevention activities focused on high risk populations.

Miscellaneous

- ❖ **Includes funds to improve electronic health record interoperability.** (Div. H; Title II) The new law includes a \$2,000,000 increase to support interoperability and information sharing efforts related to the implementation of Fast Healthcare Interoperability Resources standards or associated implementation standards.

Biomedical Research

National Institutes of Health

- ❖ **Increases overall funding for NIH.** The bill provides \$42.9 billion to fund the National Institutes of Health (NIH), a \$1.25 billion increase over Fiscal Year 2020 spending. The bill also provides \$1.25 billion in emergency COVID-19 relief funding for the NIH through Sept. 30, 2024 — divided as \$1.15 billion for research and clinical trials related to long-term studies of COVID-19 and \$100 million for the Rapid Acceleration of Diagnostics (RADx) program.
- ❖ **Allocates funds to the BRAIN Initiative.** (Div. H; Title II). The agreement provides \$560 million for the BRAIN Initiative.
- ❖ **Funds Firearm Injury and Mortality Prevention Research.** (Div. H; Title II) The agreement includes \$12,500,000, the same level as fiscal year 2020, to conduct research on firearm injury and mortality prevention. Given violence and suicide have a number of causes, the agreement recommends NIH take a comprehensive approach to studying these underlying causes and evidence-based methods of prevention of injury, including crime prevention.

Opioids

- ❖ **Supports pain therapeutics and opioid training.** (Div. H; Title II) The agreement supports training on best practices for health care providers and trainees in opioid prescribing, pain management, screening, and linkage to care for individuals with substance use disorder.
- ❖ **Directs the development of opioid prescribing guidelines.** (Div. H; Title II) The agreement directs the Center for Disease Control and Prevention (CDC) to continue its work educating patients and providers on its Guidelines for Prescribing Opioids for Chronic Pain, and to encourage uptake and use of the guidelines.
- ❖ **Encourages education on overdose prevention funding and naloxone.** (Div. H; Title II) The agreement encourages the CDC to continue working with states on naloxone education when distributing opioid overdose prevention funds.
- ❖ **Supports opioid research, education, and outreach.** (Div. H; Title II) The U.S. continues to suffer from a complex public health crisis related to opioid misuse. The agreement strongly recommends the National Institute on Drug Abuse (NIDA) continue to support research to better understand opioid use disorder, focusing on detection, prevention and treatment, and that NIDA continue to provide high-level education for health care professionals to prevent, recognize and assist in treatment and referral for opioid use disorder within their practice.
- ❖ **Encourages reimbursement for opioid alternatives.** (Div. H; Title II) The law encourages CMS to undertake efforts to ensure reimbursement of FDA-approved devices and therapies for unique post-surgery patient populations that use alternative means for effective pain management. In addition, CMS is encouraged to support provider efforts to track patient pain scores and reductions in opioid consumption using such alternative means for effective pain management.

Graduate Medical Education

Background

An appropriate supply of well-educated and trained physicians — both in specialty and primary care — is essential to ensure access to quality health care services for all Americans. Unfortunately, the nation is facing an acute shortage of physicians. Looming physician shortages — by 2033, the nation faces a physician shortfall of between [54,100 to 139,000](#) — threaten this access to care. And while medical schools in the U.S. have increased their enrollments, and additional medical and osteopathic schools have been established, the number of Medicare-funded resident positions has been capped by law at 1996 levels. To help ease this shortage and support quality resident training and education, the AANS and the CNS have advocated for legislation to increase the number of Medicare-sponsored residency training positions.

Additional Support for Residency Training and Education

- ❖ **Funds additional residency positions.** (Div. CC; Sec. 126) This section provides for the distribution of 1,000 additional Medicare-funded graduate medical education (GME) residency positions. At least 10 percent of the aggregate number of these new positions will be given to each of the following categories:
 - Rural hospitals;
 - Hospitals that are already above their Medicare cap for residency positions;
 - Hospitals in states with new medical schools or new locations and branch campuses; and
 - Hospitals that serve Health Professional Shortage Areas.

A hospital may not receive more than 25 additional full-time equivalent residency positions.

- ❖ **Promotes Rural Hospital GME Funding.** (Div. CC; Sec. 127) This section makes changes to Medicare graduate medical education (GME) Rural Training Tracks (RTT) program to provide greater flexibility for hospitals not located in a rural area that established or establishes a medical residency training program (or rural tracks) in a rural area or establishes an accredited program where greater than 50 percent of the program occurs in a rural area to partner with rural hospitals and address the physician workforce needs of rural areas.
- ❖ **Allows hospitals to host medical resident rotators for short durations.** (Div. CC; Sec. 131) This section allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full-time equivalent (FTE) resident cap or a Per Resident Amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period.
- ❖ **Increases funding for Children's Hospital GME.** (Div. H) The bill provides \$350 million for the Children's Hospitals Graduate Medical Education program, a \$10 million increase over Fiscal Year 2020.
- ❖ **Extends funding for the National Health Service Corps and teaching health centers that operate GME programs.** (Div. BB; Sec. 301) The law includes \$4 billion in funding from 2019-2023 for community health centers and the National Health Service Corps. The law also provides \$310 million in additional funding from 2021-2023 for the National Health Service Corps and

additional funding, until 2023, for teaching health centers that operate graduate medical education programs.

- ❖ **Funds health workforce grants.** (Div. H; Title II) \$50,000,000 will be available for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care provider shortage in 2025 and are limited to public institutions in states in the top quintile of states with a projected primary care provider shortage in 2025.

Surprise Medical Billing

Background

The AANS and the CNS have been advocating for federal legislation to protect patients from unanticipated medical bills (otherwise known as “surprise” medical bills) while at the same time providing for a fair process for resolving payment disputes. Organized neurosurgery adopted a [set of principles](#) for a balanced solution to the problem. After more than two years of sustained advocacy, Congress incorporated into the Consolidated Appropriations Act, 2021 ([P.L. 116-260](#)) the “No Surprises Act,” which applies to federally-regulated plans, including ERISA plans, and does not preempt state laws governing state-regulated health plans. The new law (Div. BB; Title I), which will be implemented on Jan. 1, 2022, meets many of organized neurosurgery’s principles.

General structure

- ❖ **Protects patients from surprise medical bills.** Patients are protected from surprise medical bills and only responsible for the in-network cost-sharing amount for out-of-network (OON) emergency services and other services provided at in-network facilities.
- ❖ **Requires plans to pay the provider for OON care.** Insurers must make initial payments directly to OON providers for OON services within 30 days from when the provider transmits the bill to the plan.
 - If the provider is not satisfied with the plan’s payment, they may begin a 30-day open negotiation period.
 - If an agreement cannot be reached in the open negotiation period, the plan or provider has four days to notify the other party and the Secretary of the Department of Health and Human Services (HHS) that they are initiating the Independent Dispute Resolution (IDR) process.
 - If a provider objects to the payment amount, they may still deposit the payment and then proceed to the dispute resolution process
- ❖ **Establishes a baseball-style Independent Dispute Resolution process.** IDR is initiated when the provider or plan submits a notification to the other party and Secretary of HHS. Within three business days following the date the IDR was initiated, the provider and plan jointly select a certified IDR entity.
 - The parties may continue negotiating during the 30-day IDR process and may agree on an amount of payment before the end of the IDR process (in such case, both parties will share the cost to compensate the IDR entity).

- Within 10 days of selecting the IDR entity, the parties must submit final offers, information requested by the IDR entity and any information (subject to several restrictions) the parties would like related to their offers.
- During the 30-days IDR process, the arbiter may only consider the offers made by both parties, and the following additional information — which must be given equal weight — must consider:
 - + Median in-network rate for the same service in the same geographic region. For 2022, the median in-network rate is the rate in effect on Jan. 31, 2019, increased by the consumer price index for all urban consumers (CPIU). In 2023 and thereafter, the median in-network rate is based on the previous year + CPIU.
 - + The provider or plans want to submit any information *except* usual and customary rates or billed charges, and public payors rates, including Medicare, Medicaid, CHIP and Tricare.
 - + Thy provider’s training, experience, quality and outcomes.
 - + The acuity of patients/complexity of cases, teaching status, case mix, and scope of services of the facility.
 - + Market shares of parities.
 - + Good faith efforts by parties to contract.
 - + Contracting rate history from the last four years.
- Loser pays the arbitration fees, and both providers and insurers must pay an additional fee to the regulator to be determined.
- Payment must be made to the provider within 30 days of the IDR entity’s determination.

❖ **Allows batching of similar claims** that are submitted within a 30-day period that meet the following:

- Services furnished by the same provider or facility
- Services provided to patients under the same plan
- Services are for treatment of similar conditions

❖ **Institutes a 90-day cooling-off period.** The party that initiated IDR cannot initiate it again with the *same party* and for the *same services* for 90 days. However, once the 90-day period is up, the party may submit appropriately batched claims from those 90 days to IDR.

Timely Billing, Notice, Provider Directories, Transparency

❖ **Establishes notice and consent provisions for balance billing** of non-emergency services by non-participating providers at participating facilities:

- Non-participating providers at participating facilities may not bill a patient more than the cost-sharing requirements or balance bill the patient unless the notice and consent requirements are met.
- Notice and consent requirements are met if:
 - + The patient is provided written notice and consent 72 hours in advance of the appointment.
 - + Documents provided to patients must include a good faith estimate of the costs of the services.

- + Must also provide a list of in-network providers at the facility and information regarding medical care management, such as prior authorization.
- + At participating facilities, the notice and consent exception does not apply to out-of-network providers of radiology, pathology, emergency, anesthesiology, diagnostic and neonatal services; assistant surgeons, hospitalists, intensivists and providers offering services when no other in-network provider is available.

❖ **Instructs the Secretary of HHS to implement civil monetary penalties** of up to \$10,000 for violations, but may provide a hardship exemption or waive the penalties if the provider did not knowingly violate the law and corrects with interest.

❖ **Requires plans to maintain updated provider directories.** By 2022, **plans** must:

- Verify and update directories at least every 90 days.
- Establish a procedure for removing providers unable to verify.
- Update provider information within two business days of receiving it from a provider.
- Respond to requests regarding the network status of providers within one business day.
- Retain website directory with contracted providers and directory information.
- Post information on balance billing protections, including the amount providers/facilities may charge, and appropriate federal and state agency contacts to report violations.

By 2022, **providers and facilities** must:

- Have a practice in place to ensure timely provision of directory information to a plan. At a minimum, the provider must submit to the plan:
 - + When the provider begins a network agreement with a plan.
 - + When the provider terminates an agreement.
 - + Any material changes to the content of provider directory information.

If a patient relies on erroneous directory information, the plan cannot impose a cost-sharing amount greater than in-network rates, and it must count toward the patient's in-network out-of-pocket-maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of in-network cost-sharing and the enrollee pays, the provider must refund with interest.

❖ **Requires plans to establish a price comparison tool.** A plan must offer price comparison guidance by phone and make a tool available on the internet that allows patients to compare cost-sharing amounts for a specific service/item.

❖ **Requires plans to include information on insurance cards.** Insurance cards must include deductible, out-of-pocket maximum, phone number and website for assistance information.

❖ **Requires plans to provide an advanced explanation of benefits.** A plan must provide an explanation of benefits (EOB) in advance of the service. The advanced EOB must contain the following information:

- Whether the provider or facility is participating and, if so, the contracted rate.
- If the provider or facility is out-of-network:
 - + Information on how the patient can find info on contracted physicians at the facility
 - + The good faith estimate from the provider, if applicable.
 - + A good faith estimate of the amount the plan is responsible for paying.

- + A good faith estimate of cost-sharing based on the provider's estimate and the amount to be applied to the patient's out-of-pocket maximum and deductible.
 - + A disclaimer that coverage is subject to medical management requirements, if applicable.
 - + A disclaimer that the information is only an estimate and may be subject to change.
 - + A statement that the patient may seek care from a participating provider or facility.
- ❖ **Removes gag clauses on price and quality information.** (Div. BB; Sec. 201) Bans gag clauses in contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared, under Health Insurance Portability and Accountability Act (HIPAA) business associate agreements, with third parties for plan administration and quality improvement purposes.

Other Provisions

- ❖ **Requires the following reports:**
- HHS report with the Federal Trade Commission and U.S Attorney General on the law's effects on integration, costs and access.
 - Government Accountability Office (GAO) report on the impact of the surprise billing changes on networks, access, premiums and out-of-pocket costs.
 - GAO report on network adequacy.
 - GAO report on IDR and potential financial relationships.
- ❖ **Creates a dispute resolution process for uninsured patients.** By July 21, 2021, the Secretary of HHS will establish a dispute resolution process for situations in which an uninsured patient's bill is "substantially in excess" of good faith estimate.
- ❖ **Prior Authorization.** If a health plan provides or covers any emergency services, the plan must cover emergency services without the need for any prior authorization, regardless of whether the health care provider furnishing the services is a participating provider or a participating emergency facility.

COVID-19 Relief

Background

During 2020, Congress passed five wide-ranging measures with more than \$3 trillion in COVID-19 relief since the start of the coronavirus pandemic. The laws provided business loans, direct payments, tax breaks, state and local aid, unemployment assistance, health provider and education support, and more. These laws included:

- **Coronavirus Preparedness and Response Supplemental Appropriations Act** ([P.L. 116-123](#)), which provided funding for health and international programs.
- **Families First Coronavirus Response Act** ([P.L. 116-127](#)), which included paid leave, tax credits, unemployment and nutrition assistance, and free testing.
- **Coronavirus Aid, Relief, and Economic Security (CARES) Act** ([P.L. 116-136](#)), which included more than \$2 trillion to help businesses, individuals, state and local governments, hospitals, schools, and more.

- **Paycheck Protection Program and Health Care Enhancement Act** ([P.L. 116-139](#)), which provided funding for small businesses, hospitals, and testing.

The Consolidated Appropriations Act, 2021 ([P.L. 116-260](#)) is the fifth bill, providing approximately \$900 billion in addition COVID-19 relief.

Provider Relief

- ❖ **Allocates additional monies for the Provider Relief Fund.** (Div. M, Title III) Building on prior COVID-19 relief legislation, the new law provides an additional \$3 billion for the Public Health and Social Services Emergency Fund (otherwise known as the “Provider Relief Fund”).
- ❖ **Continues the Medicare Accelerated and Advance Payments Program.** A report will be submitted on the Medicare Accelerated and Advance Payments Program every 60 days until funds are expended, providing a full accounting of the federal loans provided in FY 2020 and 2021.
- ❖ **Continues the Paycheck Protection Program (PPP) and other Small Business Support**
 - **Expands eligible expenses.** (Div. N; Sec. 304) Expands the allowable and forgivable uses of PPP loan proceeds to include:
 - + Covered operations expenditures (payment for any software, cloud computing, and other human resources and accounting needs);
 - + Covered property damage costs (costs related to property damage due to public disturbances that occurred during 2020 that are not covered by insurance);
 - + Covered supplier costs (expenditures to a supplier pursuant to a contract, purchase order, or order for goods in effect prior to taking out the loan that is essential to the recipient’s operations at the time at which the expenditure was made); and
 - + Covered worker protection expenditures (personal protective equipment and adaptive investments to help a loan recipient comply with federal health and safety guidelines or any equivalent State and local guidance related to COVID-19 during the period between March 1, 2020, and the end of the national emergency declaration.

Allows loans made under PPP before, on, or after the enactment to be eligible to utilize the expanded forgivable expenses except for borrowers who have already had their loans forgiven.

- **Expands expenses counted as payroll costs.** (Div. N; Sec. 308) Clarifies that employer-provided group life, disability, vision, or dental insurance benefits are included in payroll costs. Applies to loans made before, on, or after the date of enactment, including the forgiveness of the loan.
- **Clarifies Eligibility.** (Div. N; Sec. 310) Clarifies that a business or organization that was not in operation on Feb. 15, 2020, shall not be eligible for an initial PPP loan and a second draw PPP loan.
- ❖ **Creates a second loan from the Paycheck Protection Program,** called a “PPP second draw” loan for smaller and harder-hit businesses, with a maximum amount of \$2 million. (Div. N; Sec. 311)

- **Eligibility.** To receive a Second Draw PPP loan, eligible entities must: not employ more than 300 employees; have used or will use the full amount of their first PPP; and demonstrate at least a 25 percent reduction in gross receipts in the first, second or third quarter of 2020 relative to the same 2019 quarter.
- **Eligible entities** must be businesses, certain non-profit organizations, self-employed individuals, sole proprietors, independent contractors, and others.
- **Loan terms.** In general, borrowers may receive a loan amount of up to 2.5 times the average monthly payroll costs in the one year prior to the loan or the calendar year. No loan can be greater than \$2 million. Businesses with multiple locations that are eligible entities under the initial PPP requirements may employ not more than 300 employees per physical location. An eligible entity may only receive one PPP second draw loan.
- **Loan forgiveness.** Borrowers of a PPP second draw loan would be eligible for loan forgiveness equal to the sum of their payroll costs, as well as covered mortgage, rent, and utility payments, covered operations expenditures, covered property damage costs, covered supplier costs, and covered worker protection expenditures incurred during the covered period.
- **Application of Exemption Based on Employee.** Extends existing safe harbors on restoring full-time employees and salaries and wages. Specifically, the law applies the rule of reducing loan forgiveness for the borrower reducing the number of employees retained and reducing employees' salaries in excess of 25 percent.

❖ **Expands eligibility of 501(c)(6) organizations for loans under the PPP.** (Div. N; Sec. 318) Expands PPP eligibility to 501(c)(6) organizations, such as the AANS, if the:

- + Organization does not receive more than 15 percent of receipts from lobbying;
- + Lobbying activities do not comprise more than 15 percent of activities;
- + Cost of lobbying activities of the organization did not exceed \$1 million during the most recent tax year that ended prior to Feb. 15, 2020; and
- + Organization has 300 or fewer employees.

❖ **Prohibits the use of loan proceeds for lobbying activities.** (Div. N; Sec. 319) Prohibits any eligible entity from using proceeds of the covered loan for lobbying activities, as defined by the Lobbying Disclosure Act, lobbying expenditures related to state or local campaigns, and expenditures to influence the enactment of legislation, appropriations or regulations.

❖ **Appropriates PPP Funds.** (Div. N; Sec. 323) Extends the program to March 31, 2021, and sets the authorization level for PPP at \$806.5 billion. Direct appropriations include:

- \$284.45 billion for PPP, including \$15 billion set aside for PPP loans (initial and second draw) issued by community financial institutions, and \$15 billion for PPP loans (initial and second draw) issued by certain small depository institutions.
- \$35 billion for first-time borrowers, including \$15 billion set aside for smaller, first-time borrowers with 10 or fewer employees, or loans less than \$250,000 in low-income areas; and \$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.
- \$25 million for the Minority Business Development Centers program under the Minority Business Development Agency (MBDA); \$50 million for PPP auditing and fraud mitigation

purposes; and \$20 billion for the Targeted EIDL Advance program, of which \$20 million is for the Inspector General.

- ❖ **Clarifies tax treatment of PPP loans.** (Div. N; Sec. 276) Clarifies that gross income does not include any amount that would otherwise arise from the forgiveness of a PPP loan. The law also clarifies that deductions are allowed for otherwise deductible expenses paid with the proceeds of a PPP loan that is forgiven and that the tax basis and other attributes of the borrower’s assets will not be reduced as a result of the loan forgiveness. Provides similar treatment for Second Draw PPP loans, effective for tax years ending after the date of enactment of the provision.
- ❖ **Extends emergency Economic Injury Disaster Loan (EIDL) Grants.** (Div. N; Sec. 332) Extends covered period for Emergency EIDL grants through Dec. 31, 2021. Allows more flexibility for the SBA to verify that Emergency EIDL grant applicants have submitted accurate information and extends the time for SBA to approve and disburse Emergency EIDL grants from 3 to 21 days.
- ❖ **Repeals the EIDL advance deduction.** (Div. N; Sec. 333) Repeals section 1110(e)(6) of the CARES Act, which requires PPP borrowers to deduct the amount of their EIDL advance from their PPP forgiveness amount. Requires the Administrator to issue rules that ensure borrowers are made whole if they received forgiveness and their EIDL was deducted from that amount.
- ❖ **Permits receipt of duplicate loans.** (Div. N; Sec. 341) Permits certain EIDL borrowers to also apply for a PPP loan.
- ❖ **Extends the covered period for new PPP loans.** (Div. N; Sec. 343) Extends the covered period for all PPP loans through March 31, 2021, and applies to loans made before, on, or after the date of enactment, including the forgiveness of such loan.

Vaccinations

- ❖ **Provides additional funding for coronavirus vaccines.** (Div. H; Title III) Appropriates an additional \$8.75 billion to CDC for activities to plan, prepare for, promote, distribute, administer, monitor, and track 17 coronavirus vaccines to ensure broad-based distribution, 18 access and vaccine coverage.
- ❖ **Appropriates additional public health emergency funding.** (Div. H; Title III) Provides an additional \$23 billion to prevent, prepare for, and respond to coronavirus, domestically or internationally, including the development of necessary countermeasures and vaccines, prioritizing platform-based technologies with U.S.-based manufacturing capabilities, the purchase of vaccines, therapeutics, diagnostics, necessary medical supplies, as well as medical surge capacity and other preparedness and response activities.

For More Information Contact:

Katie O. Orrico, Director
AANS/CNS Washington Office
25 Massachusetts Avenue, NW, Suite 610
Washington, DC 20001
Email: korric@neurosurgery.org