CALIFORNIA MEDICAL ASSOCIATION

CMA BRIEF SUMMARY

Congressional Omnibus and COVID Relief Year-End Legislation:

COVID-19 Relief, Medicare Physician Payments, Extended Health Programs, and Surprise Medical Billing

On December 21, 2020, the 116th Congress will adjourn for the year after one of the most acrimonious sessions in recent history. Congress will adopt a massive $1.4 trillion spending package to fund the government and other programs and a $900 billion COVID-19 relief package. They also adopted changes to the Medicare physician fee schedule, extended several important health care programs, provided 1,000 new GME slots, and passed a surprise medical billing agreement. The ban on surprise billing will protect patients from out-of-network bills and establish a baseball-style arbitration process for insurers and physicians to resolve disputes. See the CMA highlights below.

There are nearly 40 additional health care bills that were included in the package. CMA is also working on a more detailed summary of those provisions, as well as surprise billing.

While this was a tumultuous Congress, it was also one of the most difficult and unprecedented times in our nation's history. After Congress spent trillions of dollars on the pandemic earlier in the year, Senate leadership became more cautious about future spending on the pandemic, Medicare payments, and other issues. While there are disappointments in this year-end package, Congress was able to dedicate billions to help physicians during the pandemic.

Our California Congressional leaders are already committing to future COVID aid packages, more opportunities for additional Medicare payment assistance, and surprise billing clean-up next year. Despite the difficult Congressional environment, CMA will never, ever give up. We will keep fighting so that you can focus on your patients and not be distracted or brought down by administrative burdens, declining reimbursements, outside corporate influences, or a devastating virus. You are the true heroes in this pandemic and we will continue to stand with you and advocate on your behalf.

YEAR-END COVID-19 RELIEF PACKAGE

After passing four sweeping COVID-19 relief bills earlier in the year, Congress was unable to reach another agreement until this year-end omnibus package. A summary of the latest COVID aid is listed below. This latest relief package is in addition to the trillions already dedicated to fighting the pandemic, including $185 billion for physicians and hospitals through the Provider Relief Fund, the $660 billion in the Paycheck Protection Program for practices with 50 or fewer employees, and the Medicare Advance payments not repayable for one year. The COVID-19 pandemic threatens to fundamentally alter our nation's health care delivery system and CMA will continue to push for more aid in 2021 to sustain the viability of physicians practices, maintain patient access to care, and ensure that every Californian receives a vaccine. The latest $990 billion Covid Relief package includes:

- $69 billion for vaccine purchase and distribution, testing and contact tracting, including $22 billion to help states with testing, tracing and COVID-19 mitigation.
- New $3 billion in funding for physicians and hospitals through the Provider Relief Fund.

Please note that on December 16 HHS released another $24 billion to physicians who had applied for funding on the November 6 , 2020 deadline. The total amounts to 88% of each practices lost revenues and increased costs.

- An additional $284 billion for Paycheck Protection Program forgivable loans for physician practices with 50 or fewer employees. Nonprofit organizations are eligible.

- Allows physicians to deduct expenses associated with their forgivable Paycheck Protection Program loans; expands employee retention tax credits for employers; extends a payroll tax subsidy for employers offering workers paid sick leave.
- $10 billion for child care, including for health care workers.
- $7 billion to increase broadband access, including $250 million for telehealth.
- $4.5 billion for mental health, substance abuse; waivers for mental health telehealth services made permanent.
- 1,000 new Graduate Medical Education positions.

Many more issues related to the pandemic remain unresolved. CMA urged Congress to provide liability safeguards for physicians and hospitals (beond the Good Samaritan rules) and more direct aid to the states, particularly for Medicaid but these issues were turfed to 2021. Making the telehealth waivers permanent and extending allowances for audio-only telehealth in Medicare Advantage were also moved to the 2021 Congressional agenda.

MEDICARE PHYSICIAN PAYMENT

Medicare E&M: The 2021 Medicare physician fee schedule appropriately increased long over-due primary care payment rates by up to 13% but it also reduced payments to specialists by as much as 10% because the Medicare budget neutrality rules require any payment increases to be offset with corresponding payment reductions. Medicare had also proposed a new CPT code G2211 to report complex cases. In response, CMA and AMA urged Congress to intervene and pass HR 8702 (Bera, MD; D-CA and Bucshon, MD; R-IN) which would hold specialists harmless from the 2021 payment cuts while protecting the increases for primary care.

Congress responded by stopping two-thirds of the total payment cuts and provided an additional 2% increase to defray some of the remaining cut.

- Delayed the new G2211 code for three years because it had not been approved by the RUC and gone through the normal review process. Delaying the G code also saves money and helped to reduce one-third of the specialty payment cuts.
- Committed additional funding to stop another one-third of the total Medicare payment cuts in 2021. CMA will share an impact chart by specialty as soon as it is available.

Sequestration: Congress continued the extension of the Medicare 2% sequestration cuts moratorium through March 31, 2021. This provides all physicians with a 2% payment increase January 1 to March 31, 2021.

CMA, AMA are extremely disappointed that Congress did not dedicate more funding to stop 100% of the Medicare payment cuts. However, the sequestration monies will help to defray some of the remaining cut.

Moreover, the health care leaders in Congress are committing to CMA to try to extend the moratorium on sequestration to give physicians a 2% rate increase for all of 2021. Due to arcane budget rules, if this issue is legislated during 2021, there could be a budget savings associated with it that would fund the 2% rate increase and other Medicare payment updates. CMA will be pushing for more payment to protect practices through the pandemic and ensure patient access to care.

HEALTH CARE PROGRAMS EXTENDED

Funding for several important health care programs were extended through 2023: The Community Health Centers, the Teaching Health Center primary care GME Progam and the National Health Service Corps. The ACA Disproportionate Share Hospital (DSH) payment cuts were also suspended.

"NO SURPRISES ACT" – SURPRISE MEDICAL BILLING LEGISLATION

In the last week of the 116th Congress, four bipartisan, bicameral committees agreed to a compromise bill, that includes substantial improvements sought by CMA, AMA and the federation. We have come a long way from the first committee bills that didn't even have an arbitration process and only paid median in-network rates. However, there are still a few difficult provisions that CMA and Congress will be tracking to ensure a balanced system for physicians. This new law is a better deal for physicians than California law and it will set the benchmark for CMA's advocacy to improve Califonria's surprise medical billing law. Overall, CMA will contine to fight for improvements and a system that protects patient's long-term access to physicians and incentivizies insurers to contract in good faith with physicians.

General Structure "No Surprises Act"

1. The bill only applies to federally-regulated ERISA plans that comprise 45% of California's market and does not preempt California's state laws that govern plans regulated by the state.
2. Effective January 1, 2022.
3. 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 in in-network facilities.
4. Plans required to list deductibles and cost-sharing for in-network and OON services on enrollee insurance cards.
5. Insurers required to make initial payments directly to OON providers for OON services within 30 days. The law does not define the payment rate. (CMA, AMA were *successful in eliminating the upfront interim payment rate set at the Median in-network rate paid by the insurer in the geographic region. It would have had a significant benchmark rate-setting impact, as it did in California with AB 72. In California, insurers reduced contracted rates to the interium rate in the law, and physicians have lost 81 of the 82 DMHC arbitrations because the arbitrater was heavily influenced by the interim upfront payment rate.)*
6. If a provider objects to the payment, they may still deposit the payment and then proceed to the dispute resolution process.

Dispute Resolution Process

7. There is no dollar threshold for accessing arbitration. *(CMA, AMA successfully eliminated the $750-$1,000 threshold to take claims to arbitration.)*
8. The IDR process is baseball-style arbitration which is more fair for physicians. There is no negotiation. Both parties submit a payment rate and the arbiter selects one. This process incentivizes both parties to submit reasonable rates. *(CMA, AMA fought for a baseball style arbitration process.)*
9. Providers may batch claims for the same or similar services delivered within a 30 day time period by payer. (*CMA, AMA won this provision to help improve administrative simplicity.)*
10. The first step is a 30-day informal "open-negotiation" period where physicians and insurers may settle disputes over OON claims. In Texas, 70% of the disputes have been settled in this informal process.
11. If the parties cannot agree, the physician may request a baseball-style arbitration process. The physician has 4 days to request arbitration. Independent entities will administer the arbitration.
12. The baseball-arbitration must be resolved in 30 days.
13. Once a physician has brought a batch of claims by payer to the arbitration process there is a different process for the second time and all subsequent submissions.
14. For all subsequent submissions to arbitration by payer, there is a 90-day cooling off period. It includes the 30-day informal "open negotiation process" so it is an additional 60 days. However, all claims that occur during that 90 day "cooling off" period may go directly to arbitration on day 91. There is also a provision that allows the Secretary to change the timeline for low volume claims and to ensure more efficiency. *(CMA, AMA urged Congress to reduce the cooling off period because it is difficult for small physician practices to wait 120 days to be paid. Congress changed the provision to allow physicians to collect all claims that occur during the cooling off and immediately bring those claims to arbitration. Congress added a study*

of the arbitration process and the cooling off period to better assess its impact on practices. Finally, it should be noted that the DMHC process in CA is more than 150 days and CDI at least 75 days.)

15. In the 30-day baseball arbitration process, the arbiter may only consider the offers made by both parties, and the following additional information <u>that must be considered equally</u>.
    a. Any information that the provider wants to submit except billed charges. (*There has been strong bipartisan agreement for 2 years that Congress opposes allowing physicians to submit billed charges. However, allowing physicians to submit any information is a major win. Previous bills restricted arbitration to median in-network rates only.)*
    b. Prior Contracting History for the four previous years with that payer. *(CMA and the federation also fought for this to be included.)*
    c. Median In-Network Rates as determined by the payer with timely audits by the regulator to ensure the accuracy of the median in-network rates. The regulators may also conduct audits in response to complaints. For purposes of determining median in-network rates, insurers will be held to the rates paid in January 2019 and increased by CPI annually thereafter. *(It is important to note that all of the committee bills included median in –network rates and we were told that it must remain in one place in the bill. If median is removed completely, the bill costs money and Congress did not want to cut another program to fund this legislation. CMA, AMA urged the median rate to be removed as the upfront payment rate to avoid benchmark rate setting. While we continue to oppose inclusion of median in-network rates being a factor in arbitration, we successfully added other factors that must be given equal consideration with the median rate.)*
    d. Physician training and experience, complexity of the case, acuity of the patient, good faith efforts to enter (or not enter) into network agreements, and the market share of the insurer and provider.
    e. Any information the arbiter requests.
16. The original committee agreement included an allowance for insurers to submit Medicare and Medicaid payment rates to arbitration. *(CMA, AMA strongly opposed and the final version prohibits arbiters from considering public payer rates.)*
17. Loser pays the arbitration fees and both providers and insurers must pay an additional fee to the regulator to be determined. T

Timely Billing and Notification Requirements and Studies

18. All of the burdensome timely billing and notification requirements that CMA, AMA and the federation objected to were eliminated in the final bill.
19. Insurers and providers are responsible for ensuring that insurance company provider directories are up-to-date and accurate.
20. Mandates a study by the Government Accountability Office (GAO) on ERISA plan network adequacy, access, premiums, and out-of-pocket costs.
21. Mandates a study by HHS, FTC and the US Attorney General on effects of this law on consolidation, costs, and access.
22. Mandates a GAO study on the surprise billing process, specifically including the impact of the cooling off period.
23. Establishes a grant program to create and improve State All Payer Claims Databases.

CMA will continue to work for improvements to the bill through clean-up legislation and regulation. While CMA does not support the inclusion of median in-network rates to be considered in arbitration, there are firewalls around it to protect physicians in the process and to ensure that other factors must be given equal weight in arbitration decisions.