What's in and what's out…

Donald Trump is out

Joe Biden is in
What’s in and What’s out...

Individuals are out

Community is in

Equality is out and Equity is in...
Covid Testing is out

Covid vaccines are in

What We Will Cover

1. Congress
2. White House and Federal Agencies
3. Outlook for the year(s) ahead
## Federal Response COVID-19 - Congress

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Amount of Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 6, 2020: Coronavirus Preparedness and Response Supplemental Appropriations.</td>
<td>$8.3 billion</td>
</tr>
<tr>
<td>March 18, 2020: Families First Coronavirus Response Act (FFCRA).</td>
<td>$192 billion</td>
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<tr>
<td>March 27, 2020: Coronavirus Aid, Relief, and Economic Security (CARES) Act.</td>
<td>$2.2 trillion</td>
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<tr>
<td>April 24, 2020: Paycheck Protection Program and Health Care Enhancement Act.</td>
<td>$470 billion</td>
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<tr>
<td>December 23, 2021: “CorOmnibus” Legislation.</td>
<td>$900 billion</td>
</tr>
<tr>
<td>March 11, 2021: American Rescue Plan.</td>
<td>$1.9 trillion</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5.67 trillion</strong></td>
</tr>
</tbody>
</table>
What can Congress do?

Political parties are not monoliths. Progressive and Conservative wings of each party disagree with moderate wings of the party. In the current Congress, all it takes is three House Democrats or one Senate Democrat to oppose a bill to prevent it from passing without Republican support.

Can Joe Manchin (D-WV) and Alexandria Ocasio Cortez (D-NY) find middle ground?

If not, what can Congress do?

Not much!

Infrastructure

- $550 billion “hard infrastructure” bill.
  - Bipartisan support.
  - Includes funding to expand broadband internet to underserved areas.

- $6.35 trillion “human infrastructure” reconciliation bill.
  - What is infrastructure?
  - Only Democrats will support.
  - Will bypass the filibuster by using the budget reconciliation process.

- Neither bill can pass without the other.
The looming “Fiscal Cliff”

In the next few weeks/months, Congress must:

- Pass legislation to fund the government for FY ‘22 (December 3, 2021).
- Pass legislation raising the debt ceiling to prevent a default on federal debt.
- Pass legislation preventing a 4% cut in Medicare payments due to “PayGo” associated with American Rescue Plan.
Budget Reconciliation

- Budget reconciliation is a legislative procedure used to bypass the 60 vote cloture threshold in the Senate.
- While politically advantageous, reconciliation bills have limits. The bill can only make changes in laws that substantially affect the raising taxes or spending of federal money.
- Reconciliation is used regularly by both parties. The ACA, the 2017 Tax Cuts and Jobs Act and the American Rescue Plan all used budget reconciliation as a means of getting the policies enacted.

Things on “chopping block if Budget Reconciliation is scaled back

- Adding Medicare Part B Coverage for Hearing, Vision and Dental services.
- Closing the Medicaid coverage gap in 12 states that did not expand Medicaid.
  The gap refers to people with incomes above their state’s eligibility for Medicaid but below the minimum income eligibility for federal premium assistance tax credits through the ACA insurance exchanges.
- Increasing funding for GME slots to address provider shortages.
- Health Equity Investments.
- Expanded Paid family and medical leave.
- Free community college + Expanded Higher education financial assistance.
- Extend enhanced child tax credit and earned income tax credit.
Budget Reconciliation offsets

Examples of offsets

- Corporate tax reform
- Prescription drug reforms (federally negotiated pricing)
- Tax increases on high-income earners
- Extend two percent sequestration?

Budget Reconciliation

✓ Both House and Senate pass identical budget resolutions that include instructions to Congressional Committees to identify X amount of savings/spending.

✓ The House Committees produce legislation achieving their reconciliation instructions. These bills are packaged into a single reconciliation bill by the House Budget Committee.

✓ The House has completed Committee action on the reconciliation bill and it is awaiting a floor vote.

TBD The Senate Committees produce legislation achieving their reconciliation instructions. These bills are packaged into a single reconciliation bill by the Senate Budget Committee. The Senate has NOT completed action on their reconciliation bill due to on-going disputes within the Senate Democratic Caucus as to the size and scope of the reconciliation package.

TBD Both the House and Senate pass IDENTICAL versions of the reconciliation bill. The Senate can pass this bill with 50 votes (plus the VP tie breaker).

TBD President Signs Reconciliation Bill
Surprise Medical Bills

Two sides of one coin:

Patient Protections  OON Reimbursement

What is a “Surprise Bill”? 

For purposes of the No Surprises Act (NSA), a “surprise” bill can occur when the patient receives Out-Of-Network emergency or ancillary care at an in-network facility (hospital, hospital outpatient department, ASC, CAH, freestanding ED).

NSA removes the patient from the reimbursement dispute between their health plan and the provider when the patient receives care in an NSA covered situation. Establishes a mechanism for resolving payment disputes between Health Plans and non-network providers.

The NSA protections take effect on January 1, 2022 to allow the administration to issue implementing regulations.

At this time, the NSA does NOT apply to a physician’s office. If you are a contracted provider to a hospital and you are not in-network at that hospital, the NSA requirements would apply.
**Surprise Medical Bills**

**Patient Protections**

- Limit patient out-of-pocket (OOP) charge to in-network cost sharing amount for “surprise” scenarios.
- OOP spending would count towards in-network deductible and annual OOP maximum.
- OOP charge is based on the median in-network rate.
- Patient cannot be balance billed.
- Patients removed from reimbursement dispute process.

**Independent Dispute Resolution (IDR) Process to resolve reimbursement disputes.**

- Health plans and providers will have 30 days to negotiate a payment rate. By the end of this window, the health plan will make an initial payment or denial to the provider.
- Providers would have **four days beginning on the 31st day** to trigger an independent dispute resolution (IDR) process to determine a different reimbursement rate. The parties can continue private negotiations during the IDR process.
- There is no minimum payment threshold to enter IDR, and similar claims may be batched together.
- IDR is “baseball style.” Each party submits one offer. The arbiter selects one of the offers. Arbiter’s decision is final and cannot be appealed.
IDR – What is to be considered?

The Arbitrator must select the offer closest to the qualifying payment amount unless the Arbitrator determines that credible information submitted by either party clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions.

What is the Qualifying Payment Amount (QPA)?

QPA is the lesser of the billed charge or the plan’s median contracted rate.

General consensus amongst provider groups is that the QPA is better for the Health Plans and not good for the providers.
**Surprise Medical Bills**

**In addition to the QPA, the Arbitrator can consider:**

- Information related to the training and experience of the provider,
- The market share of the parties,
- Previous contracting history between the parties
- Complexity of the services provided, and
- Any other information submitted by the parties.

The arbitrator is **prohibited** from considering government payer (e.g. Medicare and Medicaid) reimbursement rates, UCR, and the provider’s billed charge.

Similar process for OON air ambulance services.

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**Surprise Medical Bills**

**Other Provisions:**

- Provider offices must display on their website a disclosure that lists balance billing protections available to the patient.
- If a provider changes network status, patients with complex care needs have up to a 90-day period of continued coverage at in-network cost sharing rates to allow for a transition of care to an in-network provider.
- Requires health plans to have up-to-date directories of their in-network providers, which must be available to beneficiaries online, or within one business day of an inquiry. Providers must submit information to health plans for directories in a timely manner.
- Patients protected from OON bills due to inaccurate provider directory information.
No Surprises Act - Transparency

NSA - Good Faith Estimates for Uninsured (or Self-pay) Individuals

Beginning January 1, 2022 - When scheduling an item or service, or if requested by an individual, providers and facilities are required to inquire about the individual’s health insurance status or whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they are seeking. The provider or facility must provide a good faith estimate of expected charges for items and services to an uninsured (or self-pay) individual, meaning an individual that:

- Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program or a health benefits plan under; or

- Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.
Medicare Telehealth

Pre-Pandemic

* Rural areas.
* Originating Site and Distant Site.
* Professional services paid as if in-office visit. Different facility payment rate.
* Required pre-existing Medicare relationship with beneficiary.
* List of clinician-types that can bill Medicare for Telehealth.
* HIPAA-secure Audio-visual communication (with few exceptions for audio-only phone visits).
* Pre-approved list of telehealth codes.
* State licensure requirements.

Medicare Telehealth

Flexibilities During the PHE

* No rural limitation.
* Originating and distant site flexibilities let telehealth services occur from patient’s (and provider’s) home.
* No pre-existing relationship required.
* Any clinician that can bill Medicare for in-person can bill Medicare for telehealth.
* Any non-public communication method for A/V communications (FaceTime is OK, Facebook live is not).
* Expands list of covered telehealth codes.
* State licensure still applies.
White House and Federal Agencies

COVID Vaccine Mandate

President Biden has issued an Executive Order directing various agencies to adopt policies mandating individuals who:

1. Work for the federal government OR who work for a company that is a contractor to the federal government;
2. Employees of companies with more than 100 employees;
3. Work in a healthcare facility that falls under the Medicare Conditions of Participation or Conditions of Certification (i.e. hospitals, nursing homes, home health agencies, Ambulatory Surgical Centers, etc.);
4. Individuals who are contracted by one of the above to provide healthcare services in the facility.
Federal Vaccine Mandate

The Centers for Medicare and Medicaid Services (CMS) is expected to issue Interim Final Rules outlining the requirements for adhering to the vaccine mandate.

The Department of Labor will be issuing regulations governing the private employer mandate.

Medicare Physician Fee Schedule

Proposed Conversion Factor

- Proposed CY 2022 PFS conversion factor is $33.5848, a 0.14 percent reduction from the CF CMS finalized for 2021. However, the overall reduction is larger than that due to the expiration of a one-time 3.75 percent increase to the CF that Congress passed for 2021 to help mute the impacts of the evaluation and management (E/M) code values that took effect in 2021.
- For comparison, the Final CY 2020 PFS CF was $36.09.

Telehealth

- Continue coverage for Category 3 codes.
- Expands telehealth for mental/behavioral health and substance abuse treatment services.
- Continue allowing remote supervision.

Evaluation and Management

- Allows coverage for split/shared services (akin to incident-to) in the facility setting.

Allows for direct reimbursement to Physician Assistants.
Price Transparency

• Biden Administration is committed to continuing price transparency initiatives from the Trump Administration.
  – Hospitals must disclose chargemaster prices for all services in a machine-readable format.
  – Hospitals must also disclose negotiated rates with health plans for all covered services in a machine-readable format.
  – Hospitals must disclose the price of 300 common, “shoppable” services in a consumer-friendly format.

Physician practices do not need to disclose any information HOWEVER health plans will disclose their negotiated rates with practices.

Health plans must disclose out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs.

All negotiated and historical in- and out-of-network rates must be disclosed in a machine-readable format by January 1, 2022.

Initial list of 500 services required to be disclosed in consumer-friendly format beginning January 1, 2023. All remaining services must be included beginning January 1, 2024.
Looking Ahead

2022 Midterm Election

Washington’s eyes are always on the next election. 2022 Midterm elections.
- Every House seat and 1/3 of Senate seats are up.
- Midterms are historically unfriendly to the President’s party.
- Democrats control Congress with the slimmest possible majorities.

Both parties think they can win = more partisanship = more gridlock.
Look at partisan fights in Washington in the context of the next election.
Looking Ahead

Healthcare Reform – What is on the Table?

- ✗ Single Payer Healthcare
- ✗ Medicare Public Option
- ✓ Expand Eligibility for ACA Premiums
- ✓ Expand Medicare benefits to include – Dental, Vision, Hearing
- ✓ Medicaid Expansion
- ✗ Lower Medicare Eligibility Age
- 🟢 Allow Medicare to negotiation drug prices

- Avoid four percent Medicare cuts for 2022 associated with American Rescue Plan.
- ✗ Permanently expand Medicare Telehealth coverage.
- ✗ Continue transition to value-based Payment Models.
- ✗ Price transparency.
- ✗ Prescription drug prices.
- ✗ Debt ceiling/Government funding.
Health Equity

- Democrats in Congress and the Biden Administration are focusing their attention on health inequities.
  - Data collection.
  - Risk adjusting payment models.
  - Medical debt

Proposed legislation would:
- Prohibit debt collectors from collecting medical debt for two years.
- Prohibit reporting medical debt to credit reporting agencies for one year.
- Increase transparency on patient’s rights and resources for addressing medical debt.

Healthcare Spending

What does it mean for health policy?

Healthcare spending will be the main motivator behind many healthcare policies.

- Medicare’s actuaries and the Congressional Budget Office both expect the Medicare Hospital Insurance Trust Fund (that funds Part A) will be insolvent by 2026.
- Insolvency means it will not have enough money to cover the entirety of its obligations. If the Trust Fund is 90% funded, it will reimburse at 90% of the allowable amount.
- Medical inflation is outpacing consumer inflation, leading to higher household spending on healthcare.
- Healthcare already represents about one-fifth of our GDP.
- The federal government continues to shoulder most of the spending increases.
Questions?