American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Summary of Emergency Medicine-related Provisions in 2020 Year-end Congressional Package

Surprise billing:

Enacts a federal surprise billing law that applies to ERISA plans (i.e. employer self-funded) and to state-regulated plans if a state does not have its own balanced billing law.

- Deductibles for out-of-network (OON) emergency care will be the same as for in-network care.
- Insurers will be required to print a policyholder's deductibles on their insurance card—no more just having copays on there—this was a concept ACEP conceived and asked for at the start of federal efforts to legislate on surprise billing.
- Requires the Government Accountability Office to do a one-year study on network adequacy among insurers.
- The insurer must respond within 30 days of an OON claim with either a denial (such as for medical necessity) or a payment made directly to the physician.
- If there is no agreement between the insurer and physician on a payment amount following a 30-day "open negotiation" period, then either party has 4 days to initiate independent dispute resolution (IDR).
  - There is no minimum dollar threshold for accessing the IDR process.
  - All factors brought to IDR must be considered equally by the arbiter—the median in-network rate does not have primacy.
  - The median in-network amount is based on what it was on January 31, 2019, with subsequent annual increases for inflation. This will prevent insurers from being able to artificially lower the rate or game it by dropping higher-cost contracts.
  - Prohibits the IDR entity from considering the usual and customary charges, billed charges, or certain public payer [e.g., Medicare, Medicaid, CHIP, etc.] payment amounts;
  - Following an IDR determination, subsequent claims between the same insurer for the same or similar services cannot be brought to IDR for 90 days. All claims during those 90 days though can be brought to IDR once the 90 days is up.
  - A consumer portal will be updated quarterly with information on IDR outcomes.
- Includes provisions to improve health care transparency and support state all payer claims databases.

Medicare& Medicaid

E/M Reimbursement Cuts:

- An additional $3 billion to the Medicare Physician Fee Schedule to increase fee schedules by 3.75% in 2021. The mechanism operates such that services paid under the fee schedule between 1/1/2021 and 1/1/2022 will increase by 3.75%.
- A 3-year moratorium on implementation of G2211 (formerly GPC1X) complex patient add-on code until 1/1/2024 (at the earliest).
- These two changes—in addition to the increases in the ED E/M codes that ACEP will secure-- means that instead of a 6% cut on January 1, emergency physicians will see at worst a 2% reduction in reimbursement. But depending on their code mix, some may even see an overall positive increase.
- This will also exempt the additional expenditures from the PFS budget neutrality so that there isn't additional budget neutrality activity by CMS in light of this increase.

Other Medicare provisions:

- Medicare sequestration suspension will be extended for an additional three months from 12/31/2020 to 3/31/2021, preventing a 2% cut during that time.
- Telehealth – Permanently expands Medicare coverage of mental health telehealth services.
  - Does not extend/make permanent telehealth expansion from earlier COVID legislation. However, CMS has already permanently expanded many non-emergency department (ED) evaluation and management (E/M) telehealth services; for the ED E/M services, CMS has so far just expanded them through the end of the calendar year in which the COVID public health emergency ends.
- Allows physician assistants to bill Medicare directly.
- 1,000 new physician GME slots will be created starting in 2023, with preference going to hospitals in rural and underserved areas. These slots will be equally weighted between primary care and specialty.
- Rural Rotations – Allows hospitals to host limited number of residents for short-term rotations without inadvertently triggering FTE caps and PRA amounts. Allows hospitals with an FTE cap of less than 1.0 to reestablish a new FTE cap and PRA.
- A 3-year extension of the Geographic Practice Cost Index (GPCI) work floor.
- Rural Emergency Hospitals - Would allow Critical Access Hospitals and rural hospitals to voluntary convert to the newly established Rural Emergency Hospital. REHs would be focused on providing emergency department services and observation care (not exceeding an annual per patient average of 24 hours or more than one midnight) and they would have to establish appropriate transfer protocols for acute care inpatient services. It would receive a higher reimbursement rate of 105% of the Hospital Outpatient Prospective Payment System (HOPPS). ** This provision is based on the ACEP-supported "Rural Emergency Acute Care Hospital (REACH) Act" that we've been working on with Sen. Chuck Grassley (R-IA) since 2015. **
- Extends funding for the National Quality Forum for an additional three years for quality measure endorsement.

Medicaid Provisions:

- FMAP – Does not extend temporary Medicaid FMAP increase of 6.2% (from Families First Coronavirus Response Act, P.L. 115-127).
- Medicaid Disproportionate Share Hospital (DSH) Cuts – Averted for three years (FY21-23)
- Medicaid Non-Emergency Medical Transport - Medicaid statute would be amended to include non-emergency medical transportation in the list of mandatory Medicaid benefits

<u>COVID Relief</u>:

- 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.

- Paycheck Protection Program (PPP) - $257 billion
  - 501(c)(6) PPP Loans – Expands eligibility for 501(c)(6) organizations to apply for PPP funds if no more than 15% of organization's total activities are for lobbying, lobbying costs during most recent tax year did not exceed $1 million, and the organization has less than 300 employees.
- Community Mental Health Services Demonstration – Program extended through 9/30/23
- Testing & Tracing
  - $22.4 billion for State testing, tracing, and COVID mitigation programs.
  - 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.
- Vaccines/Therapeutics
  - $20 billion for Biomedical Advanced Research and Development Authority (BARDA) to procure vaccines and therapeutics
  - Nearly $9 billion to the CDC and states for vaccine distribution, 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.
  - $3.25 billion for reinforcement of the Strategic National Stockpile.
  - 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.
- Mental Health:
  - Provides $4.25 billion for mental health and substance use disorders under Substance Abuse and Mental Health Services Administration (SAMHSA).
  - Strengthens mental health and substance use disorder parity by requiring 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.
- Student Loans:
  - No extension of CARES Act pause on student loan repayment. Mandatory student loan payments are once again required after 1/31/2021.
  - Extends CARES Act tax incentives for employers to assist employees in repayment of both federal and private student loans until 2025.

Appropriations for ACEP-supported Programs:

- ALTO - $6 million.
- Sickle Cell Disease - $5 million.
- Firearm Injury & Mortality Prevention Research - $25 million ($12.5 million CDC/$12.5 million NIH).
- Traumatic Brain Injury - $6.75 million.
- Elder Falls - $2.05 million.
- MISSION ZERO – No explicit funding, but deference to House report language that encourages ASPR to pursue partnerships between military and civilian trauma care providers and requests an updated on these efforts in the FY22 Congressional Budget Justification.