

Nov. 19, 2021: National Advocacy Update

Infrastructure bill signed into law

On Nov. 15, President Biden signed into law the "Bipartisan Infrastructure Investment and Jobs Act."

In addition to creating new programs and providing increased financial support for traditional hard infrastructure projects like roads, bridges and public transit, the new law (P.L. 117-94) will make investments in a number of areas relevant to public health, such as:

- Carbon emission reduction programs, including a national electric vehicle charging network.
- Grants for replacement of lead water lines.
- Improvements to the supply chain, including a requirement that all contracts for personal protective equipment be for at least two years and be manufactured in the U.S.
- Funding to increase broadband access to underserved and high-cost areas.

Negotiations continue on the so-called human infrastructure package, also known as the "Build Back Better Act," which Congressional leaders intend to bring up for floor votes in the coming weeks.

Bipartisan members of Congress oppose implementation of surprise medical billing regulation

A bipartisan collection of members of Congress are raising strong concerns about recently released regulations implementing a federal law to curb unanticipated medical bills. Representatives Tom Suozzi (D-NY), Brad Wenstrup (R-OH), Raul Ruiz, MD (D-CA) and Larry Bucshon, MD (R-IN) sent a letter (PDF) on Nov. 5 to the Departments of Health and Human Services (HHS), Labor and Treasury urging the Sept. 30 Interim Final Rule (IFR) implementing the No Surprises Act be modified to ensure that the median in-network rate is not the default consideration during the Independent Dispute Resolution (IDR) process. The letter was ultimately cosigned by a total of 153 U.S. representatives and comes on the heels of Ways and Means Committee Chairman Richie Neal (D-MA) and Ranking Member Kevin Brady (R-TX) sending a letter (PDF) in October outlining similar concerns that the IFR fails to reflect the letter of the law and statutory intent.

As outlined in the Nov. 5 letter, "Congress passed the No Surprises Act after extensive bipartisan and bicameral deliberations to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between insurance plans and health care providers. During these deliberations, multiple proposals were considered including a benchmark rate, an independent dispute resolution (IDR) process and a hybrid. Following a comprehensive process that included hearings, markups, and extensive negotiations, Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process."

Yet, the IFR to implement the No Surprises Act instructs the certified IDR entity to start with the presumption that the median in-network rate is the appropriate payment, creating a de facto benchmark rate and implementing a policy that Congress considered and rejected. As a result, Representatives Suozzi, Wenstrup, Ruiz, and Bucshon wrote, "Unfortunately, the parameters of the IDR process in the IFR released on Sept. 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes." The letter concludes with a request for the IFR to be revised to align with a plain reading of the statutory language and specify that the certified IDR entity should not default to the median in-network rate and instead incorporate all other factors outlined in the law without favoring one criterion over the other.

The AMA applauds Reps. Suozzi, Wenstrup, Ruiz and Bucshon for their leadership on the surprise medical billing issue and continues to press the Biden administration to make changes to the implementing regulations.

Additionally, this week, the AMA and over 100 other medical associations sent a letter (PDF) to the Departments urging them to revise the most recent IFR to conform with the NSA's statutory language. Specifically, the letter ask that the Departments allow an IDR entity the discretion to consider all the relevant information submitted by the parties to determine a fair out-of-network payment to physicians, without creating a rebuttable presumption that directs an IDR entity to consider the offer closest to the QPA as the appropriate payment amount. The letter highlights the role of a balanced IDR process in ensuring fair contracting, adequate networks and access to care.

AMA summary of CY 2022 PFS final rule

On Nov. 3, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-payment Medical Review Requirements final rule.

In addition, CMS published an accompanying press release and fact sheet highlighting the key provisions contained in the final rule. The policies are scheduled to take effect on Jan. 1 and cover diverse topics, including the CY 2022 rate setting and Medicare conversion factor, telehealth and other services involving communications technology, and updates to the Quality Payment Program (QPP) through Merit-based Incentive Payment System (MIPS) activities, methodology and payment adjustments, among other provisions. The AMA continues to review and analyze the impact of key provisions contained in the final rule. Read the AMA's full summary (PDF).

Biden administration rules on vaccination mandates

The Biden administration released two rules mandating vaccination in the workplace. First, CMS issued an Interim Final Rule (IFR) mandating that health care workers at facilities participating in Medicare and Medicaid be fully vaccinated—either two doses of Pfizer or Moderna, or one dose of Johnson & Johnson—by Jan. 4. Second, the Department of Labor's Occupational Safety and Health Administration (OSHA) issued an Emergency Temporary Standard (ETS) (PDF) requiring employers with 100 or more employees to ensure each of their workers is fully vaccinated or tested for COVID-19 on at least a weekly basis by Jan. 4. OSHA will also require employers to provide paid time for employees to get vaccinated, and ensure all unvaccinated workers wear a face mask in the workplace. However, OSHA recently announced it is suspending enforcement of the ETS after the U.S. Court of Appeals for the Fifth Circuit upheld a motion to stay on it.

The facility types covered by the CMS IFR are hospitals, ambulatory surgical centers, dialysis facilities, home health agencies and long-term care facilities. The requirement applies to both clinical and non-clinical staff at these facilities, including employees, students, trainees and volunteers. Additionally, this also includes individuals who provide care, treatment or other services for the facility and/or its patients under contract as well as physicians admitting and/or treating patients in a facility. This regulation does not apply to physician offices (unless part of a larger system) because they are not subject to CMS health and safety regulations. The CMS IFR takes priority over other federal vaccination requirements. While the IFR goes into effect immediately, CMS will accept comments for 60 days.

Under the OSHA ETS, covered employers will be required to develop, implement and enforce a mandatory COVID-19 vaccination policy. As an alternative to a mandatory vaccination requirement,

employers have the option to develop, implement and enforce a policy for employees not fully vaccinated that requires weekly testing and mandatory face coverings while in the workplace. The vaccine mandate applies to all employers under OSHA jurisdiction of at least 100 employees firm- or corporate-wide. Employers must determine vaccine status of all employees, obtain proof of vaccination from all employees and maintain records of employee vaccination status. Employers must also provide support for employee vaccination, including at least four hours of paid leave to receive the vaccine, as well as reasonable paid time off for recovery of vaccine side effects.

Employees who elect to not receive the vaccination will be subject to weekly testing but employers are not required to cover those testing expenses. Additionally, all unvaccinated employees will be required to wear a face covering when indoors or occupying a vehicle with other employees. Employers may not prevent any employee from voluntarily wearing a face covering at any time unless it creates a serious occupational hazard.

While comments on the OSHA ETS will be accepted for 30 days, the ETS is effective immediately. All requirements other than the testing requirement must be met within 30 days of publication for employees who have not completed their vaccination series. Testing requirements must be met within 60 days for all employees not vaccinated. Find more information.

Also see a story in this issue of Advocacy Update, “Why court must preserve OSHA’s vaccine mandate,” which covers the AMA urging the 5th U.S. Circuit Court of Appeals to preserve OSHA’s COVID-19 vaccination-and-testing ETS for employers with 100 or more employees. The AMA also signed onto a statement along with other health care and professional organizations calling on the business community to support OSHA’s vaccine mandate.

House Energy and Commerce Committee advances "Dr. Lorna Breen Health Care Provider Protection Act"

This week the House Energy and Commerce Committee favorably reported the bipartisan “Dr. Lorna Breen Health Care Provider Protection Act.” The bill would provide grants, education and a national campaign focused on prioritizing physician mental health. The AMA submitted a letter (PDF) to the committee strongly supporting the bill. The AMA is deeply concerned about the intensifying mental health and burnout crisis among physicians and other health care professionals that has only been exacerbated by the COVID-19 pandemic.

More than half of all physicians in the United States report experiencing substantial symptoms of burnout, with the most severe symptoms occurring among those working on the front lines of medicine in fields such as emergency medicine, family medicine and internal medicine. In addition, physicians are at a significantly increased risk of suicide compared to the general population, with

suicide rates 40% higher in males and 130% higher in females. A recent study showed that, as a result of the COVID-19 pandemic, there was a median increase of 60% in physician emotional exhaustion when compared to pre-COVID levels.

Although physicians have received accolades from their communities, numerous physicians have described feeling lost, alone and unable to sleep. The last two years with the ongoing COVID-19 pandemic have been grueling, and with a looming physician shortage, we cannot afford to lose more physicians to burnout. This legislation will make a meaningful difference in recognizing burnout and prioritizing physicians' mental health, and the AMA is proud to support it.

CMS to apply MIPS extreme and uncontrollable circumstances policy for the 2021 performance year

Due to ongoing discussions and advocacy the AMA has been pursuing with CMS on the impact that the COVID-19 public health emergency (PHE) is having on physician practices, CMS will apply the Automatic Extreme and Uncontrollable Circumstances Exemption Policy (EUC) for the 2021 MIPS performance year. This 2021 policy change recognizes the continued challenges physicians face with providing care during the PHE and reduces administrative burden. Therefore, if a physician participates in MIPS as an individual, they do not need to take any action to have the automatic EUC policy applied to them. CMS will automatically identify and re-weight all four MIPS performance categories reweighted to 0% and receive a neutral payment adjustment for the 2023 MIPS payment year unless the physician submits data in two or more performance categories or has a higher final score from group or APM Entity participation.

Unfortunately, due to a systems issue, if a physician or small practice participates in the 2021 MIPS program by submitting Part B quality measures through claims and has submitted quality data codes on their 2021 Medicare claims, they will still need to file a 2021 MIPS Hardship EUC to avoid a 2023 payment adjustment and be exempt from the 2021 MIPS program.

If a group practice that typically participates in MIPS as a group has not submitted 2021 data, then the automatic EUC policy will apply to the individual physicians within the group. If the group has submitted any 2021 data, then they will need to apply for the EUC to avoid a 2023 payment adjustment.

If the physician or practice has not submitted any 2021 MIPS performance data, then the automatic EUC will apply to the physician.

PY 2021 EUC Exception Applications can be submitted by signing in to qpp.cms.gov and clicking "Exception Applications" on the left-hand navigation.

VA to review access standards for community care program

The Department of Veterans Affairs (VA) is holding a public meeting on Dec. 1 from 8:30 a.m.–4:30 p.m. Eastern time to seek information to inform the VA's review of access standards for care delivered by non-VA providers through the community care program. This follows the publication in the Federal Register earlier this month of a request for information (RFI) on the same Access Standards. The AMA is likely to weigh in. Separately, the AMA is leading a coalition of physician groups in urging the VA to allow for stakeholder engagement in the Supremacy Project, an initiative to develop National Standard of Practice for VA-employed health care professionals that could potentially expand the scope of practice for non-physicians.

AHRQ reviews the impact of health care algorithms on racial disparities

The AMA recently responded to the Agency for Healthcare Research and Quality (AHRQ) recently issued proposed key questions for its systematic review on the "Impact of Healthcare Algorithms on Racial Disparities in Health and Healthcare." AHRQ is seeking input on those questions and whether they capture all of the issues regarding clinical algorithms that may introduce bias or racism into clinical decision-making. These proposed questions follow an RFI issued by AHRQ this past spring which sought input and clinical evidence on information and evidence on clinical algorithms that may introduce bias into clinical decision making and/or influence access to care, quality of care or health outcomes for racial and ethnic minorities.

In its comments (PDF) on the proposed key questions, the AMA voiced its support of AHRQ's goals for the report, including an examination of how health care algorithms and decision tools informed by algorithms can introduce racism and/or discrimination into clinical care and how they impact inequities in access to care, quality of care and health outcomes. The AMA also outlined key considerations it believes AHRQ should take into account in its systematic review, including understanding the impact of the omission of race and/or ethnicity as proxies for structural racism and discrimination in algorithms (i.e., color- and identity-blind algorithms).

Properly designed algorithms should, in appropriate circumstances, take into account race and/or ethnicity as factors in social and structural drivers of health and use of health care resources in order

to ensure an equitable distribution of resources, conditions, opportunities and power to thrive and achieve optimal health. The AMA also advocated that AHRQ should focus on the impact of intersectionality, which describes the ways in which social and political identities within an individual overlap and interact to create greater oppression for some groups of people due to the combination of identities (e.g., being Black and a woman), throughout its review.

The AMA commends the AHRQ for its focus on this vitally important issue and will continue to engage and provide input as its review moves forward.

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