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AMERICA'S PHYSICIAN GROUPS = HEALTHCARE ON THE HILL

June 17, 2021

Welcome to America's Physician Groups' "Healthcare on the Hill," where you can get the latest on healthcare happenings in our nation's capital--and with a special focus on the value-based care movement.

As our nation continues to face many challenges, we are working to ensure you have the very latest information on our rapidly changing healthcare landscape.

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Valinda Rutledge
Executive Vice President of Federal Affairs
America's Physician Groups

Supreme Court Dismisses ACA Suit

Earlier this morning, the U.S. Supreme Court dismissed the *California v. Texas* lawsuit against the Affordable Care Act in a 7-2 ruling, which avoids the law being struck down in its entirety. The Court found that the suit from Texas, other States, and two individuals had no standing to bring the suit to federal court. The move also keeps in place the individual insurance mandate, the elimination of which led to the suit where it was argued that without the mandate the rest of the ACA should be eliminated as well. Lower courts had

struck down the mandate, in rulings that were wiped away by this decision. Justice Stephen Breyer wrote for the majority saying that the states and people who filed a federal lawsuit "have failed to show that they have standing to attack as unconstitutional the Act's minimum essential coverage provision." Despite this ruling, it is important to note that the Court did not rule on whether the individual mandate is unconstitutional now that there is no penalty for violating the individual insurance mandate.

APG Signs onto Letter to Congressional Leaders on Improving the Benchmarking Process for ACO's

This week, APG along with 12 other healthcare organizations sent a **letter** to congressional leaders applauding their sponsorship of **H.R. 3756,** the Accountable Care in Rural America Act. This bill would amend the Social Security Act to improve the Medicare Shared Savings Program (MSSP) benchmarking process and level the playing field for rural Accountable Care Organizations (ACOs) allowing them to benefit from the program.

Currently, the regional adjustment in the MSSP benchmark includes an ACO's own beneficiaries in the regional calculation. This often disadvantages ACOs that make up a large share of their market. The adjustment usually has minimal impact on ACOs with a lot of provider competition. However, the impact is significant in rural areas where ACOs cover a larger percentage of the region's fee-for-service beneficiaries and there is less provider competition.

HRSA Releases Updated Provider Relief Fund Post-Payment Reporting Requirements

On Friday, the Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA) released **revised reporting requirements** for recipients of Provider Relief Fund (PRF) General and Targeted Distribution payments. The agencies announced a number of key updates that include:

- Basing the period of availability of funds on the date which payment is received rather than requiring all payments be used by June 30, 2021, regardless of date of receipt.
    - Ex: If payment was received between July 1, 2020 – December 31, 2020, the deadline to use these funds is now December 31, 2021 instead of June 30, 2021.
- Requiring recipients to report for each Payment Received Period in which they received one or more payments exceeding $10,000 in the aggregate, rather than $10,000 cumulatively across all PRF payments

- Recipients will now have a 90-day period to complete reporting, an extension from a 30-day reporting period
- Reporting requirements are now applicable to recipients of the Nursing Home Infection Control Distribution (formally known as the Skilled Nursing Facility and Nursing Home Infection Control Distribution) in addition to General and other Targeted Distributions.
    - They do not apply to the Rural Health Clinic COVID-19 Testing Program or claims reimbursements from the HRSA COVID-19 Uninsured Program and the HRSA COVID-19 Coverage Assistance Fund (CAF)
- The PRF Reporting Portal will open for providers to start submitting information on July 1, 2021

APG will continue to monitor updates and breaking news regarding the Provider Relief Fund and share any pertinent information with members as changes to the program are made. Please email us if you have any questions.

MedPAC Releases Its Annual June Report to Congress

This week, the Medicare Payment Advisory Commission (MedPAC) released its June 2021 Report to the Congress entitled **Medicare and the Health Care Delivery System** outlining various issues affecting the Medicare program as well as broader changes in health care delivery and the market for health care services. In this edition, the Commission made a number of recommendations and analysis for Congress including:

- Reducing MA benchmarks to capture some of the efficiencies generated by the program with relatively few disruptions to supplemental benefits by implementing the following changes to MA benchmark policy:
    - Use a relatively equal blend of per capita local area FFS spending and standardized national fee-for-service (FFS) spending
    - Use a rebate of at least 75 percent
    - Integrate a discount rate of at least 2 percent
    - Use geographic markets as payment areas
    - Use the FFS population with both Part A and Part B in benchmarks
    - Eliminate the current pre–Affordable Care Act cap on benchmarks
- Streamlining CMS's portfolio of alternative payment models implementing a smaller, more harmonized portfolio of APMs to minimize overlap issues
- Responding to a congressional request covering private equity and Medicare by commissioning a report identifying gaps in Medicare's ability to collect information

about private equity investments in healthcare and examining how such investments have affected Medicare beneficiaries, providers, and MA plans

- A recommendation that Congress move all preventive vaccine coverage to Part B without beneficiary cost sharing and improve the accuracy of Medicare's Part B payment for preventive vaccines by modifying the current payment method and collecting data to enable further improvements in the future
- Recommending the following changes to policies in the Hospital Outpatient Prospective Payment System that govern which drugs are paid separately to strike a better balance between promoting access to high-cost innovative treatments and maintaining pressure on providers to be efficient:
    - Modifying the pass-through policy so that it includes only drugs that are supplies to a service and applies only to drugs and biologics that are clinically superior to their packaged analogs
    - Modifying the separately payable non-pass-through (SPNPT) policy so that it is explicitly focused on drugs that are the reason for a visit, including those that are new to the market
    - Most drugs no longer eligible for pass-through status would be eligible for SPNPT status instead. OPPS payments for these drugs would change from ASP + 6 percent under the pass-through policy to either ASP + 6 percent or ASP –22.5 percent, depending on whether the drug is obtained through the 340B program