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Welcome to "Washington Update," the weekly e-newsletter on the latest health care happenings in the nation's capital that affect APG's members.

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Advance Bundled Payments Model Extended for Additional Two Years

The Centers for Medicare &Medicaid Services (CMS) last week said it plans to extend the Bundled Payments for Care Improvement (BPCI) Advanced demonstration for two additional years, through the end of 2025, and adjust some payments made to physicians that participate in the program. Now in its fifth year, the program was set to expire at the end of 2023.

The move follows the July 2022 exit from the BPCI program of Signify Health, the largest "convener" participant in the program by number of episodes managed. Signify, which is now being acquired by CVS Health, said at the time that

changes CMS had made in the payment formula reduced opportunities for savings in the BPCI model. The move left a number of provider organizations, including some APG members, without a technology and analytics partner and threatened their ability to continue in the BPCI program. CMS now says it will reopen the enrollment process for new participants.

CMS' announcement of the two-year extension is yet another signal that the agency wants to speed the adoption of alternative payment models by allowing provider organizations a maximum number of accessible entry points into value-based care. The payment tweaks should make it more favorable for physician and other clinician participants.

Proposed CMS Rule on Prior Authorization Raises Questions About Similar Legislation

In what may or may not be an end-around Congressional legislation, CMS has sent to the Office of Management and Budget (OMB) for review a proposed rule to automate prior authorization by health plans participating in Medicare Advantage (MA), Medicaid, and the commercial markets. According to an OMB summary, the proposed rule would usher in new requirements for health plans "to improve the electronic exchange of health care data and streamline processes related to prior authorization."

Details are scarce, but the measure's scope is far broader than House-passed legislation to require electronic prior authorization by Medicare Advantage plans only. If approved by OMB and published as a proposed rule in the coming weeks, the regulation is likely to be open for public comment for 60 days. In general, the long-term impact on APG member groups of any final rule is likely to be mostly positive. The move to electronic prior authorization would clearly speed up the review process, to the likely benefit of both clinicians and patients.

On the other hand, the proposed rule would also add another interoperability reporting requirement for physicians participating in the Merit-based Incentive Payment System (MIPS) program, increasing the reporting burden on any clinicians who are still mainly engaged in fee-for-service-based Medicare payment.

It's still unclear how the proposed regulation might affect the legislative effort to enact an electronic prior authorization requirement on Medicare Advantage only. The Senate has been considering its version of the House-passed bill, but steep cost estimates by the Congressional Budget Office have posed an issue. Earlier, House proponents of the bill had expressed exasperation at CMS's lack of action, but with the agency now fully engaged in pushing through the new rule, the broader effort to force health plans to streamline prior authorization across the board may well take precedence.

CBO Examines Price Transparency on Hospital and Physician Payment

Requiring greater price transparency would not result in major savings, according to the CBO, which analyzed two potential policy approaches: Expanding or refining the current federal price transparency regulations and creating a new all-payer claims database at the federal level. If policymakers implemented both options, over a 10-year period, the prices that commercial insurers paid for hospitals' and physicians' services would fall by just 0.1 percent to 1 percent

relative to what those prices would be under current law, the CBO said in its analysis.

Almost all the impact of any price reductions would come from implementation of a federal all-payer claims database, which in turn would have the most impact in lowering prices for services deemed “shoppable” -- chiefly imaging and lab services. And even if commercial health plans passed along 85 percent to 100 percent of these savings to consumers in the form of lower premiums, the impact would be small.

It is unclear what CBO’s glum assessment of price transparency will have on policy at the federal level. Republicans, who are likely to take the majority in the House and possibly the Senate, have said that they want to examine ways to make health care more affordable to everyday consumers, and at least some still place great stock in price transparency as a means of lowering health care prices.

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