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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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Congress Contemplates Scaling Back Some Medicare Physician Payment Cuts

Physicians could be spared some of the massive cuts in Medicare payments slated to go into effect next year, but how much relief they'll receive is unknown as Congress works on an end-of-year legislative package.

As previously reported in *Washington Update*, a confluence of factors is driving these potentially large Medicare physician fee cuts, including a nearly 4.5 percent across-the-board reduction from the 2023 Medicare physician fee schedule. Congressional aides now say that they are trying to shave the cuts back to somewhere between 1.75 percent to 3 percent. Eliminating the cuts altogether is unlikely because of congressional budget rules that would require the projected additional Medicare spending to be offset by other spending cuts or tax increases. The full tab for eliminating the fee cuts is $1.6 billion for just one year of relief—a steep amount as Congress balances a number of health care priorities against a limited amount of potential fiscal offsets.

APG and other physician stakeholders continue to make preventing these cuts a top legislative priority, along with securing other measures, such as extension of the 5 percent Medicare bonus for clinicians participating in advanced alternative payment models. But the timing of any final legislative package is uncertain, and may or may not be linked to the need to extend beyond Dec. 16 the so-called continuing resolution funding many federal government operations.

CMMI: No Major Policy Changes in ACO REACH Before January Debut of Program

Officials from The Center for Medicare and Medicaid Innovation (CMMI) told APG and other physician stakeholder groups this week not to expect significant policy changes in the ACO REACH program ahead of the scheduled start date of the revamped direct contracting model in January 2023. That statement ended hopes that the agency would make near-term changes in calculating the financial benchmarks relative to historical Medicare costs that are used to measure ACO's financial performance.

However, CMMI officials expressed thanks to APG for bringing certain issues relative to the benchmarks to their attention, and said that they would continue to study the issue of how pandemic-era health care utilization patterns are affecting the benchmarks. They also said that, at APG's request, they would examine other issues expected to affect ACO REACH participants, including risk adjustment and measurement of quality performance.

Despite the absence of any major policy changes, CMMI says it is optimistic that there will be robust participation in ACO REACH following the recently reported success of the Direct Contracting model in its first performance year. CMS last week released data showing that Direct Contracting participants in 2021 generated $70 million in net savings while achieving perfect quality scores. APG members achieved some notable net savings rates, including agilon health (as much as 4.50%); Castell Direct LLC, a division of Intermountain Healthcare (2.38%); Collaborative Health Systems (1.55%); Heritage Provider Network (0.89%); Oak Street Health (15.47%); One Medical with Iora (4.93%); and VillageMD (as much as 7.45%).

In a news release, APG President and Chief Executive officer Susan Dentzer said that "this important early evidence reinforces the concept behind this model: that its strong financial incentives encourage physician practices to transform care delivery; better manage and engage patients; and achieve higher quality-of-care outcomes than are typical for Medicare patients in the traditional fee-for-service program."

'Ghost Networks' Targeted in Senate's Mental Health Parity Package

In their fifth and final draft proposal for making major changes in mental health care, members of the Senate Finance Committee take aim at Medicare Advantage plans' "ghost networks"—lists of in-network providers who exist merely on paper, but not in reality. Critics say these ghost networks have proliferated in the years since federal mental health parity legislation was first enacted, and since mental health coverage became a required feature of health insurance under the ACA. Now the committee seeks to codify the already-existing requirement that Medicare Advantage plans maintain accurate provider directories. As part of the proposal, health plans would be required to update their directories within two days of a change in a provider's status.

The proposal represents the Senate panel's latest effort to use various means at its disposal for addressing the crisis in mental health care in federal health programs. Its suite of proposed mental health changes include nearly 60 measures affecting Medicare, Medicare Advantage, and Medicaid, programs over which the committee has jurisdiction. Aside from the ghost network provision, many are aimed at beefing up the mental health care workforce—for example, by allowing Medicare to cover mental health services provided by therapists, clinical social workers, and counselors; adding 400 new psychiatry residency positions in teaching hospitals; raising payment rates to providers who integrate behavioral and mental health services; and more.

With their broad bipartisan support—but also substantial costs—the panel's far-reaching mental health proposals now seem likely to provide fodder for debate, discussion and possible action in the 118th Congress, which will take the legislative reins in January.

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