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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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Payer, Provider Ownership Comes Under Congressional Scrutiny

Legislation that cleared the House Ways and Means Committee this week could result in additional scrutiny over ownership and consolidation of health care entities; the results of horizontal and vertical integration; and the financial relationships between insurers and their

contracted providers. The bill comes amid a broad bipartisan and bicameral push to understand the effects of the market forces reshaping U.S. health care.

The committee's Health Care Price Transparency Act includes two provisions aimed at shedding light on financial arrangements between Medicare Advantage plans and providers, including physician practices owned directly by large insurance groups. Under one provision, Medicare Advantage plans would be required to report the total amount of incentive payments they pay to providers, as well as any shared losses they attempt to recoup under value-based care arrangements. A second provision would direct the Medicare Payment Advisory Commission (MedPAC) to study the impact of payer and provider integration as it relates to access, price, quality, and outcomes.

The Ways and Means legislation dovetails with a broader push to determine potential differences in utilization patterns and risk adjustment within vertically integrated physician practices compared to other types of provider groups. It also comes amid congressional concerns that health plans may be steering patients to provider groups they own, and that they may be gaming medical loss ratio requirements by pushing some administrative activities off onto medical groups.

The overall bipartisan congressional focus on greater transparency, which extends to pharmacy benefit managers, the 340b discount drug program and more, potentially means that these provisions could be folded into a broad legislative package expected in the fall. APG will continue to monitor the legislation and its impact on its member organizations.

Value Act Reintroduced in Congress

A new version of earlier legislation introduced in the House of Representatives this week aims to encourage entry into Advanced Alternative Payment Models (AAPMs) such as Medicare ACOs. The Value in Health Care Act would both continue and extend some provisions of the 2015 MACRA law and add new elements, as follows:

- Restore to their former level bonus payments for clinicians participating in AAPMs. Originally set at 5 percent under MACRA, these were trimmed by Congress to 3.5 percent this year and extended for this year only. Under the new proposal, 5 percent payments would resume for two years. CMS, rather than Congress, would determine the percentages of payments and patients seen through AAPMs for providers eligible to receive the bonuses.
- Change ACO rules that proponents say have impeded provider participation, including a distinction that CMS used to assess an ACO's ability to control spending and assume risk. It would also require CMS to be more transparent in how it determines the spending benchmarks against which ACO performance is judged and require adjustments to account for regional variations in spending.

- The bill also directs the Government Accountability Office to conduct a study between AAPMs and Medicare Advantage to seek greater alignment between the two programs.

CMS Pauses Medicaid Terminations as States Ensure Compliance with Federal Renewal Requirements

Following the end of COVID-era Medicaid protections last March, at least 3.79 million Medicaid beneficiaries were disenrolled from the program as of July 27, largely due to procedural reasons such as failure to complete paperwork. Based on data collected by the Kaiser Family Foundation from 38 states and the District of Columbia, the calculation follows the Centers for Medicare & Medicaid Services' (CMS) decision to pause coverage terminations in nine states—Delaware, Idaho, Iowa, Maine, Minnesota, Mississippi, New York, West Virginia, and Wyoming—as the agency investigates potential violations of federal renewal requirements.

CMS has instructed 35 states to address these potential violations through methods such as simplified and/or pre-populated renewal forms; additional instructions explaining what information is required to be included when completing a form; extensions of call center hours, or broad permission for individuals and organizations to assist beneficiaries with the form submission process.

APG encourages its member organizations that are contracted with Medicaid MCOs to work with them and beneficiary advocacy organizations to maintain beneficiaries' coverage and provide them assistance with the renewal process.

Justice Department and FTC Seek Comment on Draft Merger Guidelines

New draft guidelines underscoring the Biden Administration's commitment to ensuring competition through more aggressive merger enforcement are open for stakeholder comment until September 18. Although not limited to mergers of health care organizations, the updated guidelines could have major implications for the rapidly evolving health care sector.

Released July 19 by the Department of Justice and the Federal Trade Commission, the guidelines appear to continue a shift away from the "consumer welfare" standard that has long guided antitrust law. The standard effectively measures whether a given business practice or merger will raise prices, reduce output, or stifle innovation. By contrast, under Biden, these agencies are focusing more on other factors, including sheer size and serial acquisitions in a single industry.

Despite being open for comment, the guidelines are widely expected to be adopted in or close to their current form. They do not have the force of law, but they undoubtedly point the way forward for these agencies' efforts for the duration of the Biden administration. It remains to be seen whether the courts—as the final arbiter in most contentious merger cases—will ultimately go along.

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