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

Table of Contents

Proposed Medicare Fee Schedule 2025 A Mixed Bag For Physician Groups

Measures aimed at boosting ACOs and value-based care, along with a 2.8 percent Medicare physician fee cut, are among key features of the proposed 2025 Medicare Physician Fee Schedule released this week by the Centers for Medicare & Medicaid Services (CMS). The proposed fee cut may now intensify pressure in Congress to address Medicare physician payment issues later this year.

In a news release, APG cited both positive and negative aspects of the rule. Multiple provisions would benefit the Medicare Shared Savings Program (MSSP) ACOs, including one that would advance payment to ACOs with a history of earning shared savings. ACOs would also be held harmless in the event that "significant, anomalous, and highly suspect" billing activity – such as the recently discovered Medicare fraud scheme involving urinary catheters – distorted spending patterns and ACOs' benchmarks.

Challenges ahead: In addition to the fee cuts, other aspects of the proposed rule pose challenges for value-based care. With the ACO REACH model scheduled to end in 2026, CMS asks for public input into creating

an alternative: a higher risk-and-reward track for so-called ENHANCED MSSP ACOs. But CMS warns that, in contemplating such a track, it would take into account a recently released evaluation of the Global and Professional Direct Contracting (GPDC) model, the predecessor version of ACO REACH, which concluded that the model "consistently" raised net Medicare spending.

Although GPDC was created under the Trump administration – and the Center for Medicare and Medicaid Innovation (CMMI) substantially revamped it in 2022, creating ACO REACH – these poor results seem likely to increase congressional scrutiny of CMMI.

It also now falls to Congress to act to blunt the scheduled Medicare physician fee cut, as it did earlier this year, and to make permanent telehealth coverage provisions that are set to expire at year end. Although CMS proposes to add some telehealth services on a provisional basis, it warned in its own news release that unless Congress acts, pre-pandemic restrictions on telehealth coverage will go back into effect – so that "people with Medicare will need to be in a rural area and a medical facility to receive non-behavioral health services via Medicare telehealth."

APG will continue to sift through the proposed rule and present a webinar to detail the proposed rule and its implications. (Watch next week's *Washington Update* for the date.) Comments on the proposed rule are due back to CMS on September 9.

Fallout Begins Over Supreme Court Decision Shifting Power From Regulatory Agencies

As anticipated, the Supreme Court's decision overturning the so-called "Chevron deference" doctrine is bringing new pressure on federal agencies, including those with oversight on health care. With the doctrine dismissed, agencies now face intense scrutiny and legal challenges over interpretations of gaps and ambiguities in the laws they implement. Some examples:

- In Congress, the Republican chairs of key House committees have told the Department of Health and Human Services and multiple other departments and agencies that they have just days to assemble sweeping lists of regulations, guidance, legal challenges and other measures that "may be impacted by the Court's [decision]."

- In the Senate, Bill Cassidy (R-LA), ranking member of the Senate Health, Education, Labor and Pensions (HELP) Committee, has questioned whether the Food and Drug Administration will now change its practices in light of the Court's decision, pointing to the agency's assertion that it can regulate so-

called laboratory-developed tests without having been granted that authority by Congress.

- A large New Jersey health system, Hackensack Meridian Health, has sued HHS Secretary Javier Becerra in the Washington, DC, federal district court over the formula CMS used to distribute disproportionate share payments. The lawsuit cites the Secretary's "irrational and unlawful interpretation of the statutes he is entrusted to administer—which has deprived the Hospitals of the reimbursements they are due"— and references the Supreme Court's decision, which came the same day the health system's suit was filed.

Other Federal Regulations Hit Roadblocks From Federal District Courts In Texas

- The Federal Trade Commission's Non-Compete Rule can't be enforced for now against a Texas tax services firm and other litigants who challenged it in a Texas federal district court, the court ruled on July 3. The court said it would decide by August 30 on the broader merits of the case, which argues that the FTC lacked statutory authority to issue the Rule. This case and other legal challenges to the Rule are probably headed on to appeals courts and possibly to the Supreme Court.

- A cap on fees for brokers selling Medicare Advantage (MA) coverage has been stayed while another Texas federal district court readies its final judgment in a lawsuit brought by insurance agents and brokers. The cap, adopted in a CMS rule issued last April, was aimed at deterring brokers from steering Medicare beneficiaries into MA plans that weren't appropriate for them. The court will now rule on the plaintiff's multiple claims that CMS acted "arbitrarily and capriciously" in setting the cap.

In Case You Missed It

- The nation's top six pharmacy benefit management (PBM) firms now process more than 90 percent of all prescriptions - and the consolidation and vertical integration in the sector, with most PBMs owned by "corporate health care conglomerates," means that PBMs now "exercise significant power over Americans' access to drugs and the prices they pay," an interim report from the FTC

concludes. The agency reportedly now plans to sue the three largest PBMs over their tactics, and is also investigating insulin manufacturers' role in price negotiations.

- The United States continues to manifest large health and health care disparities and inequities based on race and ethnicity, with little progress made over two decades, says a recently released report from the National Academies of Sciences, Engineering, and Medicine. Among other steps, the report calls on Congress to increase funding for "effective health care delivery programs shown to improve access and quality and reduce health care inequities."

APG Announcements And Offerings

- The next **APG Government Relations/Public Policy Forum** webinar will take place on **Wednesday, July 17, 12:00- 1:00 pm EDT**. Members can register here.
- APG is expanding the focus of one of its longstanding coalitions to become the **Medicaid and Dual Eligibles Coalition**. The goal is to broaden the advocacy focus to include key issues in Medicare and Medicaid integration, particularly for patients enrolled in Dual Eligible Special Needs Plans (D-SNPs) and the providers who care for them. An introductory meeting will take place on **Wednesday, July 17, 4:00-5:00 PM EDT.** Members can register for the webinar here.
- The next **APG MSSP Coalition** webinar will take place on **Thursday, August 1, 12:00 - 1:00 pm EDT**. Members can register here.
- The next **APG Hosted Webinar, "Unlock Cost Savings Via A Proven And Scalable Dementia Care Program,"** will take place on **Tuesday, August 13, 2:00-3:00 pm EDT.** The webinar will be presented by Ceresti. For more information, including the learning objectives and speakers, click here. Members can register here.
- Want to get more involved in APG's Federal advocacy efforts? Join APG Advocates today.
- Mark your calendars now for **APG's Annual Fall Conference 2024**, November 11 – 13 in Washington, DC.

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