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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Negotiations Continue Down To The Wire On Potential Lame-Duck Health Care Package

Congressional Democrats and Republicans in the House and Senate continued to trade offers this week about elements of a potential end-of-year legislative package of multiple health care measures. But it remains unclear whether major remaining differences can be resolved before votes on a three-month extension of the fiscal 2024 continuing resolution ahead of a midnight Dec. 21 deadline.

As previously reported in *Washington Update*, the package under discussion includes the relatively non-controversial extension of pandemic-era telehealth payment flexibilities in Medicare for two years, as well as the Acute Hospital at Home waiver. Both parties have also reached agreement for now on reducing to just 0.8 percent the scheduled 2.8 percent cut in the Medicare Physician

Fee Schedule, with the necessary budgetary offsets to pay for the cost.

AI Hangup: Among key remaining sticking points is adopting legislation to speed adoption of electronic prior authorization that passed the House of Representatives in 2022. The specific disagreement is over what to do about artificial intelligence, an increasingly central engine of electronic prior authorization. As previously reported in *Washington Update* (October 18, 2024) a Senate investigative panel recently issued a report documenting the widespread use of AI in denials of post-acute care for Medicare beneficiaries – albeit with no evidence cited that the denials were inappropriate. A House bipartisan AI Task Force has discussed the use of AI in prior authorization, but has yet to issue its recommendations.

Meanwhile, Democrats have also pushed inclusion of a measure to halt pharmaceutical company patent "thickets" and claim budgetary savings to help finance other spending measures. The measure in question – part of the Affordable Prescriptions for Patients Act – unanimously passed the Senate last July. Also on the table are pharmacy benefit manager reforms as well as reauthorizations of the SUPPORT Act and the Pandemic and All-Hazards Preparedness and Response Act. Inclusion of these measures could nudge the cost of the package up substantially.

If no final deal can be reached on an end-of-year health package, it is possible that some measures could still be folded into the three-month CR extension. That would leave other elements, such as modification of the physician fee cut, to be dealt with in March, as occurred earlier this year.

Broader System Effects Of Payment And Delivery Innovation Highlighted In New CMS Innovation Center Report To Congress

The Center for Medicare and Medicaid Innovation (CMMI) is frequently criticized for the relative handful of its alternative payment models that have tested well enough to be fully adopted into Medicare. But CMMI's new report to Congress makes a strong case that successful elements of many of the more than 50 models pioneered over the years have been adopted into Medicare and Medicaid anyway – extending the benefits of experimentation to millions, beyond the formal "expansion" pathway created under the Affordable Care Act.

In this seventh biennial report to Congress, covering model activities conducted during the 2023 and 2024 fiscal years, CMMI points to notable examples. One is incorporating features of the ACO Investment Model tested from 2015-2018, whose upfront payments of prepaid shared savings to encourage providers to take on greater financial risk have since been added to the broad Medicare Shared Savings Program. The report also points out that other successful features of previously tested models have been repurposed in new ones. Examples include the mandatory Transforming Episode Accountability (TEAM) model, which builds on the earlier Bundled Payments for Care Initiative and BPCI Advanced and the Comprehensive Care for Joint Replacement (CJR) model, and the Increasing Organ Transplant Access (IOTA) model, which builds on other CMMI efforts to improve care for kidney disease patients by addressing access to kidney transplantation.

Missing the bigger picture? The report tees up a key challenge for the incoming Trump administration that has also dogged prior ones: measuring the "spillover" effects of CMMI's models, which are rarely if ever captured in formal model evaluations that frequently question model quality improvements or savings. Literature and anecdotes suggest that, when providers adopt new payment and delivery models, the effects can "spill over" to others beyond the relatively narrower group of beneficiaries attributed to the models, such as Medicare ACOs. For example, a medical group providing access for Medicare beneficiaries who are attributed to an ACO to a 24/7 nurse line is likely to make it broadly available to other patients. But these broader results are seldom if ever captured in evaluations, making the impact of the models appear far narrower and limited than it most likely is.

In a news release, APG's President and CEO Susan Dentzer congratulated Innovation Center director Liz Fowler, PhD, and her colleagues for the report and their "achievements during their tenure leading the center. They will leave behind more important building blocks for system transformation that a strong CMS and Innovation Center can carry forward in the next administration," Dentzer said.

Medicare Physician Fees Would Be Partly Updated For Practice Cost Inflation In 2026 If Congress Acts On Likely MedPAC Recommendation

As previously reported in *Washington Update* (November 8, 2024), the Medicare Payment Advisory Commission is now contemplating a draft recommendation from the panel's chair that would update Medicare physician fees in 2026 for a significant portion of practice

cost inflation. But the recommendation would amount to a one-year fix only – not a permanent change that would routinely update the fee schedule according to increases in the Medicare Economic Index. And as always, it is unclear whether or when Congress might act on the recommendation.

As discussed in the panel's public meeting this week, under the recommendation, the 2026 Medicare base payment rate for physician and other health professional services would be updated by the projected MEI for that year minus 1 percentage point. Given that the MEI is projected to increase by 2.3 percent in 2026, the Medicare physician fee schedule would then increase by 1.3 percent if Congress adopted the recommendation. Under a second part of the MedPAC recommendation, increased payments of 15 percent for primary care clinicians and 5 percent for all other clinicians would be added for services delivered to low-income Medicare beneficiaries (those receiving full or partial Medicaid benefits and/or receiving the Part D low-income subsidy). MedPAC's analysis shows that access to clinicians is worse for these beneficiaries than for the general Medicare population.

Reception of the draft recommendation was mixed among MedPAC commissioners, with some expressing the view that it was too generous, others that it didn't go far enough, and still others indicating that it hit the proverbial "Goldilocks" sweet spot. MedPAC will vote on the recommendation at its January 2025 meeting and the final version will appear in the Commission's March report to Congress.

In Case You Missed It

- A group of Democratic Senators – many of them longtime Medicare Advantage skeptics – is pressing CMS administrator-nominee Mehmet Oz about a plan he put forward as a former Senate candidate from Pennsylvania **to replace traditional Medicare with "Medicare Advantage for All."** The group added in a letter that it questioned the renowned heart surgeon's "lack of qualifications" for running the giant agency.

- President-elect Donald J. Trump said in a televised interview on Dec. 8 that while "certain vaccines are incredible, he is **"open" to allowing Health and Human Services Secretary nominee Robert F. Kennedy Jr. to investigate vaccines**, including the disproven view that they cause autism.

- A new CMS five-year framework for improving care delivery aims to tackle administrative burdens that limit a "patient's

ability to access quality, timely care" and "take time away from clinicians and their patients, contribute to inequities in care, and negatively affect the health and well-being of the nation's health care workforce."

- Detailed guidance for how alternative payment models can be structured to advance health equity is set forth in a new report from the Health Care Payment Learning and Action network.

APG Announcements And Offerings

- APG will host a **Learning Session Webinar** on **Wednesday, January 8, 1:00-2:00 pm ET**, about the Medicare Advantage & Part D Proposed Rule. You can register for the webinar here.
- APG will host a members-only Focus Group meeting on **Tuesday, January 14, 2:00 pm - 3:00 pm ET,** to solicit feedback about the Medicare Advantage & Part D Proposed Rule for APG's comment letter to CMS. MA Coalition members should watch for an email with the registration link.
- Sponsorship is now open for the **APG Spring Conference 2025**, May 14-16, in San Diego. Sign up by **December 31** to take advantage of all the additional early commitment benefits. Visit our Spring Conference 2025 sponsor website and reserve your space today!
- Want to get more involved in APG's Federal advocacy efforts? Join APG Advocates today.

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