AMERICA'S PHYSICIAN GROUPS = HEALTHCARE ON THE HILL

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Welcome to America's Physician Groups' "Healthcare on the Hill," where you can get the latest on healthcare happenings in our nation's capital--and with a special focus on the value-based care movement.

As our nation continues to face many challenges, we are working to ensure you have the very latest information on our rapidly changing healthcare landscape.

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Executive Vice President of Federal Affairs
America's Physician Groups

APG Sends Letter to HHS Responding to Articles Regarding Direct Contracting

Late Yesterday, APG and its members sent a letter to HHS Secretary Xavier Becerra and CMS Administrator Chiquita Brooks-LaSure responding to several recent criticisms against the Global and Professional Direct Contracting Pilot Program that have been recently be in the press. APG's letter responds to these misconceptions and errors as a part of our ongoing advocacy. APG underscores the importance of this pilot as a learning tool and should be re-launched to improve healthcare outcomes.

CMS Releases CY2023 Medicare Advantage and Medicare Part D Proposed Rule

Yesterday evening, the Centers for Medicare and Medicaid Services (CMS) released the **Contract Year 2023 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit (Part D) Programs** proposed rule. The rule makes numerous changes to the Part D and MA programs including:

- Requiring MA and Part D plans to expand reporting of information on the medical loss ratio to hold plans more accountable for how Medicare revenue is spent, including providing greater transparency regarding the amounts used to provide supplemental benefits (e.g., dental, vision, hearing, transportation, meals
- Establishing standardized questions in required health risk assessments on housing instability, food insecurity, and transportation to reduce health disparities
- Requiring that MA organizations with a Dual Eligible Special Needs Plan (D-SNP) establish, maintain, and consult with one or more enrollee advisory committees to ensure the experiences of dual eligible beneficiaries are considered in plan decision making
- Simplify materials that describe how to access Medicare and Medicaid services and streamline the grievance and appeals processes in certain D-SNPs
- Changing MA cost-sharing rules to foster more equitable payments to providers who serve dual eligible beneficiaries and improve their access to providers
- Limiting MA plans' ability to expand or enter into new contracts if their previous performance is poor
- Clarifying requirements for plans during disasters and emergencies to ensure that beneficiaries have uninterrupted access to needed services
- Requiring Part D plans to apply all price concessions they receive from network pharmacies at the point of sale by redefining the negotiated price as the lowest possible payment to a pharmacy, which would reduce beneficiary cost-sharing

CMS is also seeking feedback on the challenges faced in building behavioral health provider networks within MA health plans and the overall impact of potential CMS policy changes on network adequacy and behavioral health access in MA plans.

A fact sheet on the proposed rule can be found **here.** APG is currently reviewing the proposed rule and will submit a comment letter in response within 60 days.

"Build Back Better" Bill on Hold

Following Senator Joe Manchin's (D-WV) declaration last week that no new negotiations had begun over the Build Back Better bill and a report on Saturday that he had withdrawn his own $1.8 trillion counterproposal legislation, it appears that President Joe Biden's Build Back Better spending bill is now on indefinite hold. Last month, Sen. Manchin announced that he would not be voting for the bill, and despite Speaker of the House Rep. Nancy Pelosi's (D-CA) belief that the bill could still be resurrected, Democrats have instead pivoted toward voting rights legislation as their next big legislative issue. Senate Majority Leader Chuck Schumer (D-NY) said last week that the Senate would vote to on changing its rules regarding the filibuster by January 17 to pave the way for a voting rights bill.

CMS Moving Forward on Vaccine Mandates as Supreme Court Hears Legal Challenges

On Friday, the United States Supreme Court heard oral arguments in challenges to the Biden administration's authority to impose the Occupational Safety and Health Administration's (OSHA) vaccinate-or-test mandate for businesses with 100 or more employees, in addition to the Centers for Medicare and Medicaid Services' (CMS) vaccination mandate for eligible staff at healthcare facilities participating in Medicare and Medicaid. Challengers to the CMS mandate argue that CMS cannot use its general power to regulate the Medicare and Medicaid programs to impose a vaccine

mandate due to the “major questions” doctrine where Congress must clearly and unambiguously authorize agencies to implement programs that have “vast economic and political significance.” The federal government has argued that CMS has a broad mandate to protect beneficiaries’ health by conditioning payment to providers on providers meeting certain requirements, which can include vaccinated staff.

As the Court weighs the arguments and moves toward deciding the case, CMS announced last month that it would begin enforcing its mandate to facilities in the 25 states where it is not currently judicially enjoined and Washington, DC, and U.S. territories. Facilities in the 25 states where the mandate is not enjoined must comply with Phase 1 of the CMS mandate requiring staff at all health care facilities included within the regulation to have received, at a minimum, the first dose of a primary series or a single dose COVID-19 vaccine prior to staff providing any care, treatment or other services for the facility or its patients by January 27. These 25 non-enjoined states must comply with Phase 2 of the mandate, requiring staff at all health care provider and supplier types to complete the primary vaccination series or have obtained an exemption, by February 28.

CMS Withdraws Most Favored Nation Model Rule

Last week, the Centers for Medicare and Medicaid Services (CMS) issued a **final rule** that rescinded its Most Favored Nation interim final rule released last fall. The Most Favored Nation model, would have reduced Medicare payment for certain separately payable Part B drugs and tied them to the lowest prices paid by comparable foreign nations. A leftover from the Trump administration, the Biden administration first proposed rescinding the rule in August following court challenges that resulted in a preliminary injunction against the launch of the model. The model was originally set to go into effect January 1.

PHE Set to Expire on January 16 -COVID-19 Public Health Emergency Declaration

The Public Health Emergency (PHE) Declaration signed by HHS Secretary Becerra is due to expire this Sunday, January 16. Reports indicate that with the surge of the Omicron variant, Becerra will likely extend the declaration for another 90 days. HHS had previously announced that it would give states 60 days’ notice before the termination of the PHE.

CMS to Review its Recommendations on 2022 Medicare Part B Premiums

Earlier this week, HHS Secretary Becerra announced that he would ask CMS to reexamine their recommendations made in November on the nearly 15 percent increase in 2022 Medicare Part B monthly premiums. The increase would affect millions of seniors by raising their premiums from $148.50 to $170.10. Part of this reexamination is due in part to a 50 percent price decrease of the new Alzheimer’s drug called “Aduhelm” with Secretary Becerra stating that the decrease made for “a compelling basis” for CMS to do so.

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