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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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Details of Congressional Health Package Begin to Emerge

An end-of-year legislative package expected to include multiple health care provisions failed to emerge in Congress this week, even as negotiators bought time by passing a short-term continuing resolution keeping many aspects of federal operations funded through Dec. 23. Now some key details have begun to emerge as Congressional leaders meet to hash out the final "omnibus" spending package for fiscal 2023. Among key features of import to APG members, many of which could remain in flux:

- The expiring 5 percent Medicare incentive payment for clinicians participating in Advanced Alternative Payment models is likely to be replaced by a

measure that would cut the bonus to 3.5 percent and extend it only through 2023 for now.
- Retention of some of the Medicare fee cuts to physicians stemming from the scheduled 4.5 percent reduction in the 2023 conversion factor (the amount that Medicare pays for each relative value unit). Applying some "relief" funds that Congress has identified to lower the level of cuts could bring the reduction related to the conversion factor closer to 2 percent. Together with other cuts already in effect, total Medicare fee cuts for physicians would be 4 percent for 2023.
- A one-year extension of CMS's Acute Hospital Care at Home waiver.
- An extension possibly into 2024 of current pandemic-era telehealth flexibilities.
- In Medicaid, extension for five years of the enhanced Federal Medical Assistance Percentage (FMAP) payments to Puerto Rico and other U.S. territories, through 2027.
- Adoption of the bipartisan Senate HELP Committee's PREVENT Pandemics Act, which would improve strategy and coordination among the Centers for Disease Control and Prevention and other public health preparedness agencies; strengthen the supply chain and government stockpiles of medical products, such as masks, drugs, vaccines, and tests; and undertake other key measures for pandemic preparedness.

As of the publication of this newsletter, negotiations over the entire package remained fluid. APG will continue to monitor Congressional action and report again next week.

MedPAC Expected to Call for Increased Hospital, Physician Payment

Amid the debate in Congress over what to do about Medicare physician fees, the influential Medicare Payment Advisory Commission (MedPAC) has signaled that it is likely to recommend that Congress boost Medicare payments to hospitals and clinicians in 2024. Although MedPAC commissioners rarely make recommendations to increase physicians' payment, they have cited a number of reasons to do so now, including the increasingly tight labor market that is driving up wages and salaries for healthcare workers.

At the commission's public meeting on December 8-9, MedPAC commissioners proposed a base payment rate update by 50 percent of the projected increase in the Medicare Economic Index (MEI), which measures clinicians' input costs. The commission noted that although the MEI has traditionally increased 1-2 percent per year, it is projected to increase in 2022 by 4.4 percent and by 3.5 percent in 2023. The MedPAC commissioners also propose a new safety-net add-on payment to physician fee schedule payment rates to support clinicians who treat beneficiaries with low incomes. For primary care clinicians, these would equal 15 percent on top of Medicare allowed charges, and 5 percent for non-primary care clinicians.

MedPAC will meet again in January to vote on the recommendations. If approved, they could become official recommendations to Congress in June.

CMS Proposes Multiple Changes to Medicare Advantage

In the standard year-end rush to unveil policy changes, CMS this week released a proposed rule that would make multiple changes to the Medicare Advantage (MA) program, in areas ranging from prior authorization to provision of culturally competent care.

In response to concerns about prior authorization raised earlier this year by an Office of the Inspector General (OIG) report, CMS proposes changes to ensure that enrollees have timely access to medically necessary care. For example, in the absence of specific Medicare coverage requirements, MA plans would have to base coverage decisions on widely used treatment guidelines or clinical literature. In reviewing requests, MA plans would have to rely on clinicians with specific expertise in the field of medicine related to the service involved. In addition, each MA plan would need to establish a Utilization Management Committee to review policies annually and ensure consistency with traditional Medicare's coverage decisions.

The proposed rule also includes several ideas to help achieve CMS' goal of advancing health equity. For example, CMS proposes adding a health equity index reward to MA Star Ratings, beginning with 2027, based on measurement data from 2024 and 2025. The agency also proposes expanding the list of populations that MA organizations must provide services to in a culturally competent manner.

Additional key proposals include options for greater formulary flexibility for certain biological products and authorized generics to improve prescription drug affordability and access; more specific network adequacy requirements for behavioral health services; and additional protections from confusing and potentially misleading marketing.

Because many of these proposals would affect APG members, APG will convene a session in the New Year to seek feedback. If you have interest in participating, please contact Jennifer Podulka at jpodulka@apg.org. Comments on the proposed rule are due to CMS by February 13, 2023.

Better Medicare Alliance Issues Bold Medicare Advantage Recommendations

In preparation for CMS' Medicare Advantage rulemaking for 2024, Better Medicare Alliance released a forward-thinking set of recommendations focused on the program integrity of Medicare Advantage and ensuring that plans are even more responsible and accountable for the costs and high quality of enrollees' care. Proposed changes include revamping CMS' risk adjustment data validation (RADV) audit process to require annual audits of all MA plans; refining criteria for in-home Health Risk Assessments (HRA); making oversight of marketing and broker communication more robust and establishing best practices for managed and coordinated supplemental benefits.

APG generally endorses the thrust of the BMA proposals, and in particular, those pertaining to program integrity. At the same time, APG recognizes that proposals may need to be fine-tuned in its members' interests and in line with earlier comments filed with CMS in response to its recent request for information. APG's board Federal Policy Committee and its new Medicare Advantage Coalition will be discussing these and other proposals pertinent to MA plans early in 2023. Please watch future editions of Washington Update for additional announcements.

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