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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Medicare Physician Fees Outlook Uncertain Amid Evolving House And Senate Plans

The 2024 Medicare Physician Fee Schedule rule released this week appeared to cement in place more physician fee cuts, with the Centers for Medicare & Medicaid Services finalizing a 3.4 percent reduction in the so-called conversion factor – the dollar multiplier used to convert adjusted relative value units into payment amounts for physician services. But now evolving plans in the Senate and House could either ameliorate the pain or further postpone the prospects for any congressional relief.

A proposal for relieving at least some of the pressure emerged this week in bipartisan draft legislation put forward by leaders of the Senate Finance committee. The broad package, which includes measures to expand the mental health care workforce and postpone cuts in Medicaid disproportionate share payments for hospitals, would also trim the 3.4 percent physician fee reduction in 2024 to 2.15 percent.

Some But Not Enough: Although an improvement, the measure would mean that Medicare physician fees would continue to fall even as the Medicare Economic Index — the measure of inflation faced by physicians in practice costs and wages — is projected to rise by 4.5 percent in

2024. The Senate package would also extend for one more year the Medicare fee bonus for clinicians participating in Advanced Alternative Payment Models (AAPM), although it would further reduce the bonus from 3.5 percent for the 2023 performance to 1.75 percent in 2024. Liz Fowler, director of CMS's Innovation Center, told attendees at APG's fall conference this week that the movement to value-based care would "lose ground" if the bonus expired altogether.

Meanwhile, the prospects for relief were further clouded by the evolving picture in the House of Representatives. With just days left before stopgap government funding expires on Nov. 17, House Speaker Mike Johnson (R-LA) this week floated a plan with Senate leaders to pass a new continuing resolution to extend current funding through mid-January. Although such a plan would avoid a near-term partial government shutdown, it compounds uncertainties about all measures that might otherwise be in a year-end spending package – both modifications to looming cuts in Medicare clinicians' fees or an extension of the AAPM bonus.

Johnson has told Senators that the House will need the extra weeks to complete work on fiscal 2024 appropriations bills that remain unfinished. But extending a deadline until mid-January will only delay a reckoning with the Senate over gaping differences in spending levels and multiple other issues.

As the clock ticks forward, APG will keep members apprised of all these ongoing developments.

Innovation Center Director Pushes Back On Dismal Savings Estimates

The Congressional Budget Office's (CBO) recent analysis that the Center for Medicare and Medicaid Innovation (CMMI) cost $5.4 billion more than it saved Medicare over ten years neglected complex realities of health care transformation, the center's director, Liz Fowler, said this week. Released in September, CBO's analysis estimated that CMMI spent $7.9 billion to operate its innovative payment and delivery models from 2011 to 2020, but that those models had reduced Medicare spending by just $2.6 billion over the period.

Fowler said that the CBO review was incomplete because it did not count "spillover effects" of savings from one model tested by the center to others; presented a distorted picture by disregarding savings from the separate Medicare Shared Savings Program; and ignored the fact that multiple CMMI models needed to pay incentives to draw providers to participate, or required investments since they focused on "underfunded" areas, including rural or underserved communities. Fowler's comments came at APG's annual fall conference in Washington, DC, where she and

other CMS and CMMI colleagues spoke to a joint meeting of several of APG's advocacy coalitions.

Spillover effects: Fowler said CMMI's own series of so-called synthesis papers set forth a more nuanced understanding of the Innovation Center's results, both in terms of Medicare savings as well as broad changes in care delivery and quality. One of the factors that Fowler pointed to — spillover effects — is a case in point, she said. "We know there is a spillover effect" when CMMI tests a particular set of interventions from the attributed population on which it is tested to the broader health care market. When the model is evaluated, however, trends seen in a comparison group are treated as independent of the model intervention group. As a result, the model can appear to have achieved less impact in savings or in quality improvements than it actually has. The fact that the CBO analysis aggregated the results of 49 past evaluations of CMMI models could simply have compounded the effect.

CBO has also acknowledged that its analysis of CMMI did not capture savings from the separate Medicare Shared Savings Program (MSSP), whose design has in fact been "informed by the experience of ACOs that [CMMI] has operated." And at a recent Senate Budget Committee hearing, the CBO's director of health analysis, Chapin White, acknowledged the problem of determining how much money is saved from alternative payment models given spillover effects and broad changes in care delivery. In CBO's attempts to evaluate recent savings from MSSP, he said, it was "harder to find reasonable control groups" against which to measure relative savings from ACOs, presumably because so many Medicare beneficiaries have been attributed to ACOs, or because changed care patterns such as reduced hospitalization have spread more broadly throughout the population.

Spending slowdown: In any case, White told senators at the hearing, the combination of no net Medicare savings from CMMI models, and small net savings from MSSP, meant that the combined effects of alternative payment models played no real role in the sharp slowdown of per-beneficiary Medicare spending growth since 2005. To the degree that CBO itself overestimated Medicare spending from 2010-2020, the office has acknowledged, it was due to lower-than-expected prescription drug spending. Other drivers of the spending slowdown were low growth in provider payment rates and reduced spending on patients with cardiovascular conditions thanks to greater use of medications and better control over risk factors, such as hypertension.

White House Directive Aims For Robust Review Of Artificial Intelligence In Health Care

A task force created by the Secretary of Health and Human Services (HHS) must develop a framework for using artificial intelligence (AI) in the

health sector under a sweeping executive order that the Biden administration released this week. The task force will have a year to propose policies governing the use of AI in such areas as biomedical research and discovery; drug and device safety; health care delivery and financing, and public health. Separately, the agency must also develop an "assurance policy" to evaluate the performance of AI-enabled health care tools, both for "pre-market assessment and post-market oversight," the directive says.

The executive order comes amid a rush of new AI-enabled health care products, along with growing concerns about potential risks to safety and quality; lack of transparency about the use of algorithms; and potential bias in AI systems. ChatGPT and similar applications have recently "opened the floodgates," leading to a range of tools such as documentation systems that capture clinical encounters in real time and automatically generate notes, said John Halamka, MD, president of Mayo Clinic Platform, at APG's fall conference this week.

Many of these tools could boost efficiency in health care, but others could also pose risks if used to inform clinical care without considerable physician oversight, Halamka and other AI experts who spoke at the conference agreed. To that end, the executive order also directs HHS to establish an AI safety program to capture "clinical errors resulting from AI deployed in healthcare settings" as well as "a central tracking repository for associated incidents that cause harm, including through bias or discrimination, to patients, caregivers, or other parties."

APG Announcements And Offerings

- APG will host two Deep Dive Webinars this month. One on "**CMS's Plans to Integrate Episodes into Total Cost of Care Models**" that will take place on Thursday, November 9 at noon ET. Register for the meeting here. The other on "**The 2024 Medicare Physician Fee Schedule and Shared Savings Program Final Rule**" that is scheduled for Thursday, November 16 at noon ET. Register for this meeting here.

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