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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As Partial Shutdown Is Averted, The Fate Of Key Health Measures Remains Uncertain

President Biden signed into law Congress's latest can-kicking exercise this week, as new deadlines for reaching agreement on federal spending bills were officially postponed to early March. Although the move averted partial shutdowns of the government on Jan. 19 and Feb. 2, it left up in the air the fate of key health provisions for another six weeks or more.

Despite a push by the Republican Doctors' Caucus, a measure to modify the Medicare physician fee cuts that took effect on Jan. 1 was not included in the temporary spending agreement — the so-called continuing resolution, or CR — that pushed the deadlines off to March. Also omitted from the CR was an extension of the Medicare bonus for clinicians participating in advanced alternative payment models (AAPM). Temporary funding is now in place for community health centers, but a longer-term measure to reauthorize funding for the centers awaits the broader agreement on fiscal 2024 spending bills in March — or later.

In the interim, APG will continue to press for a modification in the Medicare physician fee cut and extension of the AAPM bonus, in hopes that both measures will eventually make it into law this year.

New Rule To Speed Up And Streamline Prior Authorization Decisions

Health plans across the board — whether providing insurance in Medicare Advantage, Medicaid, the Children's Health Insurance Program, Medicaid managed care, or through qualified health plans under the Affordable Care Act — will have to meet strict new timeliness standards in responding to prior authorization requests under a new rule from the Centers for Medicare & Medicaid Services (CMS). The regulation, set to be officially adopted on Feb. 8, will also boost the electronic processing of prior authorization information in the interest of streamlining an often prolonged and arduous process.

In adopting its rule, CMS accepted some of APG's recommendations, such as that there be a seven calendar-day turnaround on prior authorization requests involving standard care. CMS also determined that urgent care requests should be responded to in no more than 72 hours. APG had recommended that 72 hours indeed be the standard, arguing that imposing an even faster timeline was unrealistic.

Streamlining The Process: To boost the electronic exchange of prior authorization information, three new types of software — known as application program interfaces, or APIs — must be adopted by payers by 2027 to enable different types of computers and devices to communicate with each other.

One, called the Provider Access API, will allow providers with whom the patient has a treatment relationship to access more information about their patients as they formulate a prior authorization request. Another — the Payer-to-Payer API — will enable data sharing among payers, including claims and encounter data, to support patient care coordination. Still another, called the Patient Access API — which would enable consumers to download prior authorization responses directly to their mobile phones — will also require payers to include information to help patients understand the prior authorization process and its impact on care.

"APG's providers, who are in value-based arrangements and seek to take accountability for costs and quality, believe that prior authorization is critical to reducing low-value health care, which costs money and can be harmful to patients," said Susan Dentzer, APG's President and CEO, in a news release this week. "At the same time, prior authorization is often a blunt and misused instrument that poses obstacles to patients obtaining

necessary care in a timely way." Given these realities, she termed the many important changes adopted by CMS "welcome and overdue."

Federal Regulatory System Faces Threat In Cases Before The Supreme Court

Federal agencies such as CMS would face major obstacles in interpreting laws and publishing regulations if plaintiffs prevail in two cases currently before the Supreme Court. They involve a rule known as "Chevron deference" — a principle derived from a 1984 case involving the Chevron company, which requires courts to defer to federal agencies when they interpret ambiguous provisions of laws enacted by Congress.

Lawyers in the two cases currently before the Court are asking that this precedent be overturned. In oral arguments this week, several justices voiced skepticism about the power bestowed on federal agencies by the Chevron deference doctrine. Others suggested that federal agencies, with their scientific and technical expertise, are better situated than courts to resolve ambiguities in a federal statute, and that moving in a new direction would cause chaos. "Congress can hardly see a week in the future," said Supreme Court Justice Elena Kagan, noting that few congressionally enacted laws can fully anticipate the complexities of applying statutes to the real world.

A decision in the case is expected during the current Supreme Court term.

MedPAC Hikes Its Estimate Of Excessive Spending In Medicare Advantage

The Medicare Payment Advisory Commission (MedPAC) has reignited a firestorm by more than doubling its estimate of how much more the federal government pays for Medicare beneficiaries who enroll in Medicare Advantage (MA) versus the fee-for-service (FFS) program. The estimate shared by MedPAC's last week is that MA enrollees cost 23 percent more than their FFS counterparts — a startling jump from the six percent differential that MedPAC included in its March 2023 Report to Congress.

The staff analysis, which sparked intense disagreement among MedPAC commissioners, is based on several features of MA payment. These factors include generous benchmarks that were established by Congress to encourage MA plan participation throughout the country; risk adjustment that increases payment rates for sicker enrollees — a methodology that is open to criticism thanks to the use of health risk assessment, chart

reviews, and other means of driving up risk score; and so-called favorable selection — the alleged result of MA enrollees being even healthier than their actual risk scores indicate. The commission's staff also argues that MA's quality bonus program, based on Star Ratings, is costly and doesn't measure quality well.

As previously reported in *Washington Update*, MedPAC has been exploring the concept of favorable selection along with the impact of diagnosis coding differences. Yet there is a growing body of evidence that MA plans better manage and coordinate care for enrollees, resulting in improved outcomes and lower out-of-pocket spending. New data based on analyses of APG members' and patients' experience in MA buttresses this case. APG looks forward to publishing these data in the coming months.

APG Announcements And Offerings

- APG will host an Emerging Trends in Health Care Webinar with guest Adam Boehler, former director of the Center for Medicare and Medicaid Innovation, on Monday, January 22, at 12:30-1:00pm ET. Register here.
- As APG discussed in a webinar on October 26, CMS has introduced a new Guiding an Improved Dementia Experience (GUIDE) Model and has opened the Request for Applications (RFA) portal. Applications are due by January 30, 2024.
- Registration is open for the APG Spring Conference 2024, May 29-31, in San Diego. APG members can save $300 with the Super Early Bird rate (February 29 deadline). Register here.
- Want to get more involved in APG's Federal advocacy efforts? Join APG Advocates today.

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