Welcome to *Washington Update*, the weekly e-newsletter on the latest health care happenings in the nation's capital that affect APG's members.

Table of Contents

Hiking Medicare Physician Payment, Particularly For Chronic Disease Management, Is Focus Of Senate Panel Hearing

Lawmakers from both parties expressed concerns over the need to boost Medicare physician payment – and provide clinicians with more resources to manage patients' chronic diseases – as the Senate Finance Committee launched a series of hearings on these topics this week. Despite the many fiscal and political obstacles, at least some senators suggested that they were serious about making major reforms.

Although some lawmakers have raised concerns about producing merely "another band-aid" on Medicare physician payment, "what we want to do is fundamental change," said the panel's chair, Sen. Ron Wyden (D-OR). Emphasizing the urgency, ranking member Mike Crapo (R-ID) pointed to the 2023 Medicare Trustees' report as heralding that "the colossal gap between stagnant [Medicare providers'] fees and steep inflation poses a dire threat to long-term patient access."

Fee schedule changes: Witnesses at the hearing sought to tie the importance of making changes in the Medicare Physician Fee Schedule (MPFS) with additional reforms to boost the rewards for care coordination. Patricia Turner, MD, executive director and chief executive officer of the American College of Surgeons, addressed the need to update the MPFS annually for increases in practice cost inflation, as well as incorporate new quality measures rewarding coordinated care into Medicare's Quality Payment Program.

Wyden and other supporters of earlier reforms to enhance chronic care management, such as the 2018 CHRONIC Care Act, also voiced the need for major steps forward to care for growing populations of older adults with cancer, diabetes, hypertension and other chronic conditions. They vowed to work with members of a newly formed Medicare payment working group and the Senate Budget Committee on potential legislative solutions to these growing problems.

Extending And Augmenting Pandemic-Era Telehealth Flexibilities Back On The Table In Congress

Multiple changes in Medicare payment policy that boosted telehealth use during the pandemic are set to expire at the end of the year, prompting new discussions about not only extending them, but also giving them more permanent traction. To those ends, a House panel this week debated a range of related issues, including the wisdom of extending Medicare fee-for-service payment for telehealth, ensuring the quality of virtual visits for Medicare beneficiaries, and maintaining guardrails to avoid overuse and fraud.

Witnesses and lawmakers voiced different perspectives on perpetuating many of the telehealth flexibilities enacted during the COVID-19 public health emergency, including paying for audio-only "visits" with providers at the same rate as in-person visits. One witness, Frederic Riccardi, President of the Medicare Rights Center advocacy group, protested that paying full Medicare visit rates for all forms of telehealth indefinitely "could create financial incentives that undermine access to in-person care, putting beneficiary health and agency at risk." Others disagreed. "It is in the best interest of all Medicare beneficiaries that a permanent extension of the pandemic-era telehealth flexibilities be enacted," testified Lee Schwamm, MD, a developer of telestroke care and a member of an American Heart Association expert panel advising that group's Center for Telehealth.

Role of alternative payment models: As lawmakers discussed bills that would permanently remove geographic and originating site restrictions on the use of telehealth in Medicare (H.R. 134), or mandate studies on the telehealth flexibilities (H.R. 1110), they also probed whether making broad

payment for telehealth a permanent feature of the traditional fee-for-service Medicare program could lead to overutilization. At least one witness said the evidence suggested that it would. “The current fee-for-service system is poorly suited for doing telehealth,” said Ateev Mehrotra, MD, MPH, professor of health care policy and medicine at Harvard Medical School. “You don’t want to pay for each portal message, phone call, and so forth,” as opposed to incentivizing providers through bundled payments or capitation to use telehealth judiciously. “The growth of telehealth has emphasized the need for those alternative payment models,” Mehrotra said.

It is broadly anticipated that any measures to extend telehealth flexibilities could be incorporated into a spending package toward the end of the year, possibly in a lame-duck session after the November elections. Whether telehealth flexibilities are temporarily extended or made permanent could depend on cost estimates of whatever final package is shaped.

Private Equity And Other For-Profit Investment In Health Care Continues To Draw Scrutiny

A proposed “Health Over Wealth Act” drafted by Senate Health, Education, Labor, and Pensions Committee member Ed Markey (D-Mass), requiring greater transparency in health care entity ownership by for-profit entities, is the latest congressional bid to illuminate private equity and other for-profit investment in health care. Release of the discussion draft followed an April 3 field hearing in Boston, where local lawmakers have asked federal regulators to probe Optum’s proposed acquisition of Steward Health Care's physician group. (APG counts a number of Optum-owned physician groups among its members, including Masssachusetts-based Reliant Medical Group.)

Markey’s bill closely tracks legislation proposed last year by Representative Pramila Jayapal (D-WA) that would require disclosure of much information about such investments to the Department of Health and Human Services. APG will continue to watch it and similar proposals and report on developments to its members

APG Announcements And Offerings

- CMS proposed a new mandatory episode-based alternative payment model — Transforming Episode Accountability Model

(TEAM) — building on lessons learned from the Bundled Payments for Care Improvement Advanced and Comprehensive Care for Joint Replacement Models. The proposed model will be finalized through rulemaking and is planned to launch on January 1, 2026, and run for five years, ending on December 31, 2030.

- APG will host a members-only informational webinar on the 2025 MA and Part D Final Rule on Monday, April 29, 12:00 – 1:00 pm ET. Register here.
- APG will host two members-only focus groups on the Medicare Advantage Request for Information: the first on Wednesday, April 24, 12:00 - 1:00 pm ET (register here) and the second on Thursday, May 2, 12:00 - 1:00 pm ET (register here).
- APG will host an Emerging Trends in Health Care Webinar on May 16, 12:00 pm – 12:45 pm ET, with guest Rebekah Gee, MD, CEO of Nest Health. Register here.
- Registration is open for the APG's Spring Conference in San Diego from May 29-31. Register here.
- Want to get more involved in APG's Federal advocacy efforts? Join APG Advocates today.

Know people who may enjoy receiving *Washington Update*? Forward this email and have them contact communications@apg.org to be added to the subscription list. Visit APG's website for more news and resources, or contact a member of APG's Washington, DC, policy and communications team below.

Valinda Rutledge, EVP, Advocacy and Education . . . . . vrutledge@apg.org
Jennifer Podulka, Vice President, Federal Policy . . . . . jpodulka@apg.org
Garrett Eberhardt, Executive Director, Medicaid Policy . . . . . geberhardt@apg.org
Greg Phillips, Director of Communications . . . . . gphillips@apg.org