AMERICA'S PHYSICIAN GROUPS

WASHINGTON UPDATE

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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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Medicaid Cuts In House-Passed Budget Bill Bode Enrollment Losses As Potential Medicare Threat Looms

Republican House leaders managed to unite enough of the fractured membership to pass reconciliation legislation this week in part by beefing up cuts in Medicaid now estimated at nearly $700 billion over ten years. As the bill now moves to the Senate, uncertainty remains over whether that body will embrace the same set of changes in Medicaid and separate Affordable Care Act provisions – all of which could cause roughly 15 million people to lose health coverage, shift

more costs to states, punish states that use Medicaid funds to cover immigrants, and overall shrink funding for physicians, hospitals, and the health care system. At the same time, fears are growing that the large increases in federal budget deficits that the legislation would produce could also necessitate $500 billion in mandatory Medicare cuts under separate budget sequestration provisions.

The single biggest Medicaid change in terms of dollars cut from the program – new mandatory Medicaid work requirements – was expanded in the final House bill by moving the implementation date up by two years to year-end 2026, a step likely to accelerate resulting coverage losses. Another change drastically expanded measures to punish states that use their own or federal funds to extend Medicaid coverage to immigrants, either undocumented or lawfully resident with qualified status. The federal match for the Medicaid expansion population in 33 states and the District of Columbia that cover these immigrants would fall from 90 percent to 80 percent – shifting up to $153 billion in costs to these states over a decade and probably forcing them to drop or scale back coverage. A moratorium on new provider taxes and new limits on state-directed payments would reduce federal Medicaid spending by $161 billion over the decade, according to a Congressional Budget Office analysis.

Massive Medicare Cuts? Because the House bill could increase the federal debt by an estimated $3.1 trillion over the decade, it would trigger the process of enacting automatic federal spending cuts to enforce budget limits known as sequestration. Unless Congress waived the requirement – by a required 60-vote margin in the Senate – another $500 billion in Medicare spending cuts would then be required. APG will follow the action as the bill moves to the Senate and increase its advocacy against the package.

Stepped-Up Auditing Of Medicare Advantage Plans To Assist In Addressing Overpayments

An expansion of government audits on Medicare Advantage plans' risk adjustment data will review all plan contracts annually and clear a several-year audit backlog, the Centers for Medicare & Medicaid Services (CMS) announced this week. The announcement addresses concerns voiced by APG and others that the audits are essential to rooting out overcoding and enhancing confidence in the current risk adjustment system.

CMS conducts Risk Adjustment Data Validation (RADV) audits to confirm that diagnoses used for risk adjustment payment are supported by medical records. However, the agency is currently only

able to audit approximately 60 MA plans a year – out of 3,719 MA contracts currently – and acknowledges that it is several years behind on completing even these. The agency says it will use "enhanced technology" and dramatically increase its team of medical coders from 40 to 2,000 to audit every plan annually and eliminate the backlog by 2026.

CMS said in its release that federal estimates suggest that MA plans may erroneously or inappropriately overbill the government through risk adjustment by $17 billion annually. APG noted in its recent *Medicare Done Right* report that it "vigorously opposes inappropriate upcoding or overcoding of diagnoses purely for the purposes of boosting payment to MA plans" and advocated for increased RADV audits. APG has further emphasized that this strategy is the most appropriate one for eliminating overpayments to MA plans pending a broader overhaul of the risk adjustment system.

ACO REACH Participants To Face Major Changes In 2026 To Enhance Government Savings

ACOs participating in the Realizing Equity, Access, and Community Health (REACH) model will face tough new requirements next year due to multiple changes announced by the CMS Innovation Center. The changes respond to preliminary estimates that the 132 ACO REACH participants actually spent nearly $1.3 billion more than the benchmark spending target in 2023, rather than achieving Medicare savings, although quality across multiple measures improved. The CMS Innovation Center recently reiterated its commitment to fulfilling its "statutory mandate to produce cost savings" for the government and taxpayers.

Under the newly announced changes, all REACH ACOs will see greater payment restrictions that could force them to share more savings with the government and that would hold back a greater portion of payments that they can earn back later through improved quality performance. In addition, a shift in the calculation of the spending benchmarks against which their performance is measured, as well as tighter caps on the growth of risk scores that help to determine ACO payments, will combine to intensify pressure on participants to achieve savings. APG will hold a special meeting of its ACO REACH Coalition next month to discuss the impact of these changes on participants (see more information in "APG Announcements and Offerings" below).

Some good news: The detailed preliminary evaluation contained some welcome news for APG's ACO REACH members. For example, ACOs that elected global (higher) risk-sharing and total cost of care capitation

reduced spending, whereas those that elected professional risk-sharing with primary care capitation increased spending. ACOs that were networks of individual physician practices also reduced spending, while integrated delivery/hospital system ACOs increased spending. These results add to the evidence that ACOs across the board achieve greater savings when led by physician groups versus hospitals or health systems. But in the end, even the more successful arrangements only achieved gross savings; once they received shared savings, no net savings to Medicare were achieved.

Trump Administration's Sweeping "Most-Favored-Nation" Drug Pricing Proposal Would Set New High Watermark For Price Controls

Prices for all U.S. branded pharmaceuticals not facing direct competition from generics or biosimilar drugs would be linked to an index of lower overseas drug prices under new targets announced this week by the Department of Health and Human Services (HHS). The new maximum prices would apply across all markets – Medicare, Medicaid, commercial, and otherwise – in what would clearly be the most draconian price controls ever attempted on pharmaceuticals in the United States.

Under the new plan, so-called most-favored-nation (MFN) price targets will be set to the lowest price charged by any of a group of relatively rich counties within the 38-nation Organization for Economic Co-operation and Development (OECD). (The relevant countries would need to produce per-capita income equal to 60 percent of the U.S. level, thereby excluding relatively poorer OECD nations such as Greece.) Specific U.S. price targets that pharmaceutical companies will have to meet are to be calculated in the coming weeks, after which they will have 30 days to voluntarily lower prices before facing regulatory action. Separately, the Trump administration has also proposed that U.S. consumers and other entities would then be able to buy drugs from manufacturers directly for those prices without going through their insurance companies or pharmacy benefit managers (PBMs).

Opposition: PhRMA, the main pharmaceutical trade group, has previously lambasted the Trump administration's proposal as "importing foreign prices from socialist countries" and jeopardizing pharmaceutical innovation and jobs. It is considered likely that industry players will seek to block the proposal in court.

Meanwhile, several bipartisan bills have been introduced in the Senate aimed at curbing prescription drug pricing through similar approaches. For example, Sen. Bernie Sanders (I-VT)

recently reintroduced a most-favored-nation bill while Sen. Bill Cassidy (R-LA) says that he is preparing similar legislation.

In Case You Missed It

- As expected, the first report of HHS's Make America Healthy Again Commission focused on four drivers of childhood chronic illness: poor diet, environmental chemicals, chronic stress, and lack of exercise. Absent was discussion of the most common chronic diseases in children, such as tooth decay and asthma. The MAHA report called for clinical trials on whole-food diets, and questioned vaccine safety.

- Starting this fall, COVID booster vaccines will be recommended only for adults 65+ and for all persons above the age of 6 months with one or more risk factors that put them at high risk for severe Covid-19 outcomes, a still substantial share of the population, according to recommendations outlined by the Food and Drug Administration's new leadership. The FDA also announced that vaccine manufacturers Pfizer and Moderna will be required to expand warning labels of myocarditis and pericarditis for males 16-25.

- A bill that would streamline prior authorization for Medicare Advantage plans by establishing a new electronic process and standardizing transactions was reintroduced in the Senate by a bipartisan group of lawmakers. The bill, which has been endorsed by APG, has previously had strong bipartisan support in both chambers and passed the House in 2022.

- Aligning itself with new strategies coming out of CMS's Innovation Center, the Health Care Payment Learning and Action Network told stakeholders in an email that it will shutter its existing panels and launch four new initiatives focused on health care choice and competition, patient empowerment, preventative care, and technology-enabled healthcare. The LAN will also discontinue its longstanding efforts to measure the extent of alternative payment model adoption, a setback for the value-based care movement.

APG Announcements And Offerings

- APG will host two upcoming *APG member-only* focus groups on:

    - **The Request for Information (RFI) on Deregulation of the Medicare Program** on **Tuesday, June 3, 12:00 pm – 1:00 pm ET**.
    - **The Request for Information on health information technology in Medicare** on **Thursday, June 5, 3:00 pm - 4:00 pm ET**.
- To register for one or both of these virtual focus groups, please email Jenifer Callahan at jcallahan@apg.org.
- Due to the significant changes coming to ACO REACH in 2026, APG will host a special meeting of the **APG ACO REACH Coalition** on **Wednesday, June 11, 3:00 pm - 4:00 pm ET**. This meeting is open to members only, to register please email Jenifer Callahan at jcallahan@apg.org.
- APG will host an **Emerging Trends in Health Care** webinar featuring Dr. Kavita Patel on **Tuesday, June 17, 12:00 pm - 12:45 pm ET**. Register here.
- APG launches **Case Studies in Excellence 2025**: APG members are invited to submit an innovative care initiative or best practice in value-based care for the next edition of Case Studies in Excellence. Learn more and submit your abstract here.
- **Up to 10 APG members focused on dementia care with at least 30 percent of Medicare patients enrolled in Medicare Advantage,** are eligible for technical assistance support through the National Dementia Care Collaborative (NDCC) thanks to support from The John A. Hartford Foundation. To connect with the NDCC team and apply for this opportunity, visit the NDCC website here.
- Want to get more involved in APG's Federal advocacy efforts? Join APG Advocates today.