AMERICA'S PHYSICIAN GROUPS

WASHINGTON UPDATE

July 3, 2025

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

With Reconciliation Bill On Its Way To President's Desk, Health Care System Steels For The Impact

Capping a marathon push, the giant Republican reconciliation bill has now cleared both houses of Congress and is expected to be signed into law by President Trump on Friday, July 4th. With implementation of many provisions scheduled to begin as soon as next year, the nation's health care system now faces the impact – including $1 trillion in federal Medicaid spending cuts over the next decade and unraveling of much of the progress made since passage of the Affordable Care Act (ACA) to extend health insurance coverage to millions of Americans.

House GOP members closed ranks this week and accepted a more draconian Senate version of reconciliation legislation that had passed that body just days earlier. The legislation's provisions

affecting Medicaid, the Children's Health Insurance Program (CHIP), and the ACA's marketplace coverage – along with new limits on certain immigrants' eligibility for Medicare – are now expected to increase the number of uninsured by 11.8 million in 2034, according to the Congressional Budget Office (CBO). Medicaid cuts that are roughly 18 percent larger than in the original House bill passed in May include even greater restrictions on provider taxes and the state-directed payments that raise Medicaid payment to designated providers to Medicare levels or more. KFF's analysis shows that 22 states could now be required to reduce their provider taxes on either hospitals or managed care organizations, cutting a key source of state Medicaid funding in those states.

Coverage rollback: Coupled with other recent ACA regulatory changes, and a de facto decision to let the pandemic-era enhanced ACA premium tax credits lapse, CBO estimates that a total of 17 million individuals could lose health coverage – the "biggest rollback of health insurance coverage ever due to federal policy changes," wrote Cynthia Cox, vice president and director of the Affordable Care Act program at KFF. Federal Medicaid spending in rural areas alone is estimated to decline by $155 billion over ten years – far exceeding the $50 billion appropriated for a new "rural health transformation fund" created to soften the blow. Enforcing new Medicaid work reporting requirements is likely to add massive administrative expenditures to state budgets, while meeting them could prove especially harmful for millions with unstable employment or those who are not working because of "a health problem or disability, difficulty finding work, or caregiving responsibilities," an Urban Institute analysis says.

In a small boon for clinicians, the legislation will hike the Medicare Physician Fee Schedule by 2.5 percent in 2026, following a nearly 3 percent decline in 2025. But as APG noted in a statement, the measure stops well short of adjusting the fee schedule permanently for a portion of practice cost inflation, and is thus likely to cause ongoing real declines in physician fees that Medicare's trustees have said will reduce beneficiaries' access over time. Additional harm to Medicare – which President Trump vowed would remain untouched in the legislation – is now likely to result from so-called sequestration cuts driven by a projected $4.1 trillion increase in federal debt. And as the Committee for a Responsible Federal Budget has noted, the legislation will also advance the projected date of insolvency of Medicare's hospital insurance trust fund and Social Security's Old Age and Survivors' trust fund to 2032.

Moving on: Despite lack of success, APG is proud of the extensive advocacy that it and other stakeholders conducted to defeat the legislation and will maintain its advocacy to reverse or moderate its health care provisions over time.

New Innovation Center Model Targets Key Sources of Waste To Test Stepped-Up Prior Authorization In Traditional Medicare

The CMS Innovation Center (CMMI) is attempting a new twist on its statutory authority to "test innovative payment and service delivery models" by ramping up prior authorization for high-cost services in the traditional – or "original" – Medicare program. In its newly announced Wasteful and Inappropriate Service Reduction (WISeR) model, CMMI will partner not with health care providers as usual, but for the first time with technology companies adept in streamlining prior authorization.

The target is a group of products and services deemed especially subject to fraud, waste, and abuse, including skin substitutes, electrical nerve stimulator implants, and knee arthroscopy for osteoarthritis. In six states (Arizona, New Jersey, Ohio, Oklahoma, Texas and Washington) and for a specified group of services, providers will either have to submit a prior authorization request or undergo a post-service, pre-payment review, while the tech companies earn a share of savings linked to how much they avert wasteful and inappropriate care.

Spending crackdown: The model, which will debut next year and run through 2031, comes as CMMI now doubles down on initiatives that will produce savings for Medicare. Part of that strategy now apparently includes instigating more utilization management in traditional Medicare, where use of such approaches has been relatively rare. As Medicare itself notes on its website, "In most cases, you **don't need approval** (prior authorization) for Original Medicare to cover your services or supplies," in stark contrast to the broad use of prior authorization in Medicare Advantage. Any advance reviews of services undertaken in traditional Medicare were "manual and slow, taking over a week, [so] the contractors who administer the process often didn't use it for fear of delaying needed service," noted Eliot Fishman of CMMI in a LinkedIn post. The disparity between these two parts of Medicare has contributed to staggering increases in "significant anomalous and highly suspicious" billing for costly skin substitutes that has been flagged by ACOs in traditional Medicare, including some APG member organizations.

The planned WISeR model could now give CMS an important tool to cut off such billing at its source. Applications from eligible entities that can improve prior authorization and interface with the Medicare Administrative Contractors that pay the bills in the traditional program are due July 25, according to a CMMI fact sheet.

In Case You Missed It

- Medicare reimbursement for home health agencies would fall by 6.4 percent, or about $1 billion, in 2026 under a proposed rule advanced this week by the Centers for Medicare & Medicaid Services (CMS).

- A new joint working group on health care fraud formed by the Departments of Justice and Health and Human Services will probe potential False Claims Act violations in multiple priority areas, including Medicare Advantage, drug and devices pricing, and violations of network adequacy requirements, among others.

- A federal district court in Rhode Island ruled that the mass firings at HHS were probably unlawful, and that the department must halt its plan to consolidate agencies and cease any further firings, in a case brought by attorneys general for 19 states and the District of Columbia.

- The public comment period is now open for Medicare Drug Price Negotiation Program Initial Price Applicability Year 2028. Comments are due by August 29, 2025.

- More than 14 million people could die over the next five years from diseases like AIDS, tuberculosis, and malaria due to funding cuts to USAID, according to a new analysis published in *The Lancet*.

APG Announcements And Offerings

- APG will host an **Emerging Trends in Health Care** webinar featuring **CMS Deputy Administrator and Chief of Staff Stephanie Carlton** on **Tuesday, July 22, 12:00 pm - 12:45 pm ET.** Register for the webinar here.
- Participants in APG's **Group Purchasing Program** will describe their innovative products in two forthcoming webinars.
    - The first features **Altura, GoGo, and Ventegra** on **Tuesday, July 22, 4:00 pm – 5:00 pm ET.** Register for the webinar here.
    - The second features **Accorded, Medicare on Demand, and Plannery on Tuesday, July 29, 4:00 pm – 5:00pm ET.** Register for the webinar here.

- APG has partnered with **Health Industry Collaboration Effort, Inc. (HICE)** for an informative webinar on the **Provider Appointment Availability Survey (PAAS): What You Should Know** on **Wednesday, July 23, 2:00 pm - 3:00pm PT.** Register for the webinar 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.