

# Advocacy Update



March 25, 2025

# Trump Administration Health Team



**RFK Jr.**

- **Heather Flick**, Chief of Staff
- **Stefanie Spear**, Principal Deputy Chief of Staff

- **Russel Vought**, OMB Director
- **Theo Merkel**, Domestic Policy Council
- **Dr. Joel M. Zinberg**, National Economic Council



**Dr. Oz**

- **Stephanie Carlton**, Acting Administrator, Chief of Staff
- **Kimberly Brandt**, Deputy Administrator, COO
- **John Brooks**, Deputy Administrator, Chief Policy and Regulatory Officer
- **Chris Klomp**, Director of Medicare
- **Alec Aramanda**, Deputy Director of Medicare
- **Abe Sutton**, Director of CMMI
- **Drew Snyder**, Director of Medicaid

# Trump Priorities & Accountable Care



## Trump Healthcare Priorities

- **Healthcare was not a campaign priority**
- **Robust and free competition**
  - Policies that increase supply of healthcare providers in rural areas
  - Offload risk from the government
- **Patient choice**
  - Control of healthcare dollars with the patient
  - Sustainability and value for beneficiaries
- **Provider autonomy**
  - Avoid irrational reimbursement schemes
  - Reduce regulatory compliance burdens
    - Emphasis for rural
    - End quality measurement complex
    - Move away from restrictive and complicated FFS approaches to VBC approaches
  - Unleash innovation
- **Transparency**
- **Reduce fraud, waste, and abuse**

## Accountable Care Addressing Priorities

- **Focus on health**
  - Reduction of chronic illness burden
  - Focus on primary care
  - Focus on nonmedical contributions to health (nutritional, behavioral)
- **Robust and Free Competition**
  - Groups of providers compete, with insurers as well
  - Pathway for providers to take on risk
  - *MSSP is on-ramp to higher risk models like GPDC, small rural/independent need significant time with lower risk to progress to direct contracting/capitation*
  - All providers should have pathways for managing risk of populations
- **Patient Choice**
  - Additional choice for healthcare coverage, driven by patient provider selection
  - Patient autonomy with supportive management from ACOs
  - Patients receive enhanced benefits beyond what's covered in Medicare\*
- **Provider Autonomy**
  - Moves away from FFS structure and regulatory burden
  - Tech-enabled healthcare
- **ACOs serve a critical role in identification of fraud, waste, and abuse; led the identification of massive catheter fraud**

# Trump Priorities for VBC



## Project 2025 Highlights

- Regulations to reinstate:
  - MCIT: expedited coverage for FDA-designated breakthrough devices
  - RADV
  - MAQI: exempt providers from MIPS for participating in MA VBC arrangements
  - GPDC, currently known as REACH
- Needed statutory changes:
  - VBC: replace FFS with VBC payments; eliminate MSSP; remove barriers to direct primary care; ensure shared savings and reference pricing benefits consumers
  - MA: default option for enrollment, reconfigure risk, remove restrictions on benefits/services; give beneficiaries direct control of dollars
  - Price transparency: codify and strengthen, revisit No Surprises Act
  - Remove restrictions on physician-owned hospitals

# Trump Priorities for VBC



## Paragon Institute

- Eliminate VBC
  - End MIPS and other pay-for-performance programs; CMS should facilitate reporting and publication of all-payer data that is useful to patients, payers, other third parties
  - Eliminate AAPM incentives, if retained focus on all-payer participation, proportional bonus based on level of adoption
- Enact permanent payment reforms in traditional Medicare such as episode and population-based payments
- Reduce overpayments and reform PFS to incorporate market-based pricing (e.g., MA rates)
- Recent policy brief: [Two Pathways for Medicare's Future: MA and ACOs](#)

# Revisiting Past Trump Admin Approaches



- Mandatory risk
- Mandatory participation
- Geographic Direct Contracting
- Rural Focused Model (CHART)

# Challenges with Growing Accountable Care



- Sustainability and predictability
- Inadequate budgets (benchmark) to manage patient population
- Misaligned incentives— remaining in FFS can be the stronger financial option
- Investment required to transition to value
- Burden associated with quality reporting

# Driving Accountable Care Adoption



- Retain and boost competition through sustainable pathways for APMs
  - Extend GPDC until 2030, create a pathway for permanence
  - Direct Primary Care (i.e., ACO PC Flex) available for all MSSP ACOs
  - Incentives to join value across all lines of business
    - Require Medicare Advantage to report on VBC contract availability and adoption
  - Ensure long-term financial viability for VBC (improve benchmarks)
    - Remove the ACPT from MSSP and reconsider approaches to improve benchmarks
    - Identify opportunities to align benchmarks across MA and ACOs
- Enhance patient choice by allowing patients to choose VBC entities
  - Expanded voluntary alignment (align GPDC and MSSP, simplify, remove restrictions for homebound patients)
  - Enhanced beneficiary education on options for DC/ACOs; eliminate follow-up notification in MSSP
- Provider autonomy
  - Simplify quality measurement: streamlined approach that can be used across payers and uses measures meaningful to patients
  - Create pathways for all providers to participate in VBC arrangements
  - Continue to shift payment arrangements away from FFS; promote payment arrangements within total cost of care (primary care, specialty payments)
  - Expansion of allowable services/benefits for providers at risk: expanded and simplified waivers

# Recent Updates



## CMMI Announcements

### Early Termination of Models:

- Making Care Primary
- Primary Care First
- ESRD Treatment Choices
- VT ACO Model (transition to AHEAD)
- MD TCOC (transition to AHEAD)

## NAACOS Advocacy

### ACPT in MSSP

- Inaccurate prediction of spending
- Request CMS reweight to 0%
- ***Sign-on letter coming soon***

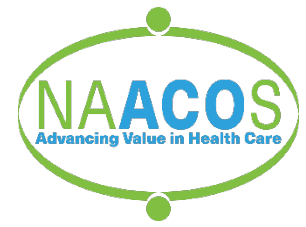
### Skin Substitutes

- Continuing to see inappropriate use
- Requesting CMS make changes to SAHS policy

<https://www.naacos.com/naacos-call-on-benchmark-issues-acpt-and-billing-for-skin-substitutes/>

### Focus on Reduction of Chronic Condition Burden/Specialist Engagement

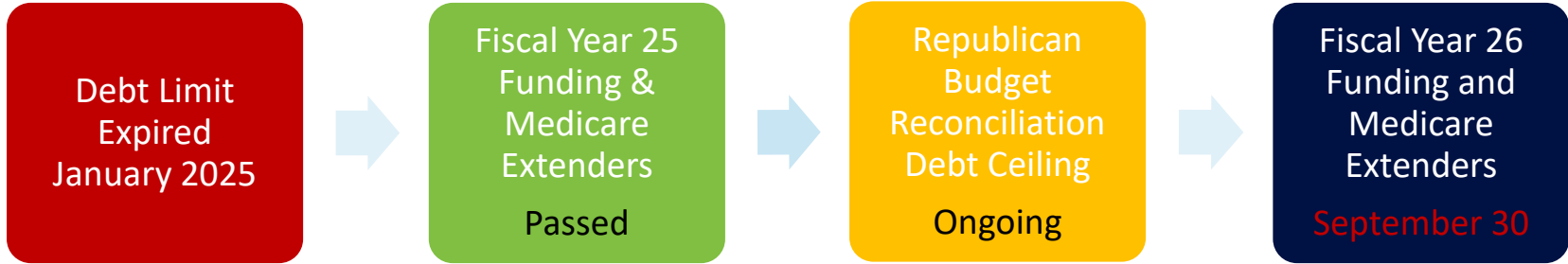
- [Pre-conference](#) session on specialty care VBC arrangements across payers
- Best practices on approaches for referral networks/P4P, episodes, population-based models



# Congressional Update



# Govt Funding Update



Continuing resolution (CR) enacted into law on **March 14, 2025**, extends funding for federal programs and expiring health provisions through **September 30, 2025**.



The agreement **includes** a temporary extension of Medicare’s current telehealth waivers, the hospital at home program, and other expiring Medicare/ Medicaid programs.



CR did **not** extend APM incentives, address increase in APM qualifying thresholds, or stop physician payment cuts that began Jan 1.

# 119<sup>th</sup> Congress Medicare Bills



## Medicare Bill Introduced

**APMs:** Extends Medicare’s AAPM incentives @3.53 percent for payment year 2027 and maintains 2024 revenue and patient thresholds for qualifying APM status.

**Physician Payment:** Stops Medicare’s 2.83 percent payment cut for 2025 and provides physicians with a 2 percent payment update for the remainder of 2025 (April 1- Dec 31).

**eCQMs:** Delays mandatory eCQM reporting until 2030 and maintains all reporting options (including Web Interface). Requires CMS to pilot test prior to mandatory eCQM transition for ACOs.

## Medicare Bills Under Development

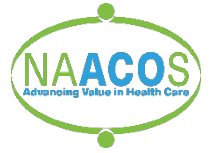
**ACO Assignment:** Expands ACO assignment to more non-physicians.

**CMMI Transparency:** Establish more transparency in the development of benchmarks (i.e., RTA).

**Hospital Site-Neutral:** Bipartisan framework to reform hospital site-neutral payments and reinvest portion of savings into rural and VBC hospitals.

**Medicare Flex Funds Accounts:** Establish Roth-style health savings accounts for Medicare that could be included in CMMI models/ Medicare Advantage to encourage more participation in ACOs/ APMs.

# Budget Reconciliation



- Allows majority party to pass budget bills with simple majority (No Senate Filibuster)
- Since the 1980s, budget reconciliation has been used to enact 23 bills, including:
  - ✓ Affordable Care Act
  - ✓ Bush and Trump Tax Cuts
  - ✓ American Rescue Plan
  - ✓ Inflation Reduction Act

## GOP Reconciliation Policy Goals

| <b>Taxes</b>            | <b>Funding Increases</b> | <b>Funding Reductions</b>                 |
|-------------------------|--------------------------|---|
| Extension of tax policy | Defense & Immigration    | Mandatory Programs<br>(Medicare/Medicaid) |
| +\$5-10 trillion        | +300 billion             | -\$1 or 2 trillion                        |

# Members of Congress Must Hear From You



Reach out to your lawmakers and ask them to:

- 1) Extend Medicare's APM incentives/ address qualifying thresholds
  - 2) Stop physician payment cuts
  - 3) Delay eCQMs requirements
- See the NAACOS [legislative priorities](#) for talking points and contact Rob Daley for additional assistance.

*Coming Soon:* Alliance for Value-Based Patient Care sign-on letter to Congress

# Registration Now Open

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**Spring 2025 Conference**

**April 22–24, 2025**

**Hilton Baltimore Inner Harbor**

[Register here!](#)

