March 3, 2023

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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APG Raises Awareness in Congress on CMS's Medicare Advantage Advance Notice

APG members helped to raise awareness in Congress this week around the Centers for Medicare & Medicaid's (CMS) proposed changes in the risk adjustment model for Medicare Advantage (MA). Meeting with staff from offices of both Democratic and Republican Senators, physicians from ChenMed, Optum, WellMed Medical Group, and Wellvana shared how specific proposed code changes would impair their ability to care for chronically ill patients – many of whom would be low-income and from racially and ethnically diverse communities.

As noted in previous *Washington Update* newsletters, CMS estimates that the overall impact of its risk adjustment overhaul would result in about a 3 percent reduction in risk scores on average across MA plans in 2024. Even so, coupled with other changes, CMS says, MA plan payments would rise 1 percent overall. Changes in plan payments would normally be expected to be passed

along to contracted providers. Although the effects of the proposed changes appear to vary across APG member groups, many APG members anticipate a much greater impact on their overall risk scores and revenue losses as high as 12 to 17 percent. The impact appears to be especially pronounced on groups with large numbers of low-income, racially and ethnically diverse populations with high rates of conditions such as diabetes. These anticipated effects track with other analyses, which show potentially major impact from sharply lower risk scores on MA Special Needs plans (SNPs) in particular.

The perspectives that APG members shared appeared to resonate with at least some congressional staff, and in turn are prompting conversations among members of Congress, CMS, and the White House Domestic Policy Council. The overall impact remains unclear. Following the March 6 deadline for filing comment letters responding to the Advance Notice, CMS has 30 days to finalize and publish its final regulation.

APG remains hopeful that CMS will grant at least one of its three requests: that the risk adjustment changes be placed on hold for a year pending further examination; that specific changes be made in coding decisions that would have the greatest impact on APG groups; or that the changes overall be phased in over two to three years, to give the most affected plans and provider groups greater time to adjust.

MedPAC Explores Options for MA Benchmarks and Risk Adjustment

With about half of all eligible Medicare beneficiaries now enrolled in MA plans, the issue of setting spending benchmarks for a variety of programs – from MA to Medicare ACOs – based on spending for a dwindling population of Medicare fee-for-service beneficiaries is rising to the fore. The issue constitutes a growing concern for APG member groups engaged in MA and the range of Medicare alternative payment models, since the performance of participants in these value-based payment models may increasingly be judged against assumptions about Medicare spending that hold increasingly less meaning over time.

The Medicare Payment Advisory Commission (MedPAC) took up the issue this week, signaling that it may examine options for how Medicare Advantage (MA) benchmarks should be set in the future.

In the commission's March 2-3, 2023, public meeting, MedPAC staff listed three options for additional consideration: competitive bidding among MA plans, to reach a market-based determination of spending levels; benchmarks based on blending both fee-for-service (FFS) and MA spending data; and updating MA benchmarks using a fixed growth rate. During a robust discussion, commissioners expressed enthusiasm for taking up the topic, but did not settle on any of these three options.

The largely technical discussion at times veered into other aspects of the Medicare Advantage program, including an assertion by MedPAC staff that risk scores, on average, overpredict spending for the MA population. According to this theory, "favorable selection" – meaning that healthier MA beneficiaries tend to sign up for MA – explains situations in which MA costs are lower for enrollees than their risk scores would predict, and is driven by MA plans' benefits, network, and other design decisions.

MedPAC staff presented data showing that MA beneficiaries who moved from traditional fee-for-service to MA—and then stayed in the program for multiple years—had less spending over time. The staff concluded that this result stemmed from favorable selection, as opposed to being the result of proactive steps by MA plans and providers to keep enrollees healthier over time. A growing body of evidence suggests that MA plans better coordinate and manage care for patients with multiple chronic conditions, thus decreasing their utilization of expensive medical services like ED visits and hospital admissions and improving their quality of care.

Two commissioners, including MedPAC Chairman Michael Chernew and commissioner David Grabowski—both affiliated with Harvard Medical School—cautioned against the use of so-called switching analysis, which studies movements of consumers or beneficiaries between coverage options and the larger patterns of behavior that emerge from them. They suggested that there are ample reasons for exploring options for setting benchmarks without the need to turn to this type of study. Given that these types of switching studies look at correlation, not causation, they are inherently unable to conclude that favorable selection motivates switching and in turn, that favorable selection is what is driving lower MA costs.

MedPAC will include an "informational" chapter with no recommendations in its June report to Congress, and the topic may be revisited later in the year or next year. APG plans a breakout session on the issue of options Medicare spending benchmarks for its spring conference in San Diego, June 1-2, 2023.

MACPAC Examines Experiences of Dually-Eligible Populations in Integrated Care Plans

Beneficiaries covered by both Medicare and Medicaid, nicknamed "dual eligibles," are largely satisfied with their coverage, according to interviews conducted recently by NORC at the University of Chicago on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC). Still, beneficiaries expressed varying levels of satisfaction based on the type of Special Needs Plan (SNP) in which they were enrolled, with slightly less satisfaction in highly integrated plans designed to better align delivery, payment, and administration of both Medicare and Medicaid.

In 2020, just over 12 million individuals were enrolled in both Medicare and Medicaid, with Medicare as the primary payer for acute and post-acute care services while Medicaid covers the balance of medical services. NORC conducted focus groups with 55 dually-eligible Medicare enrollees —21 of whom were in a so-called Coordinated-Only dual-eligible SNP (CO D-SNP) and 34 of whom were covered by plans with higher levels of integration.

Participants cited key positive aspects of their experience, including low or no out-of-pocket costs, which they said was the most important factor in choosing a SNP plan. Another positive attribute cited by participants was access to providers, in both primary care and specialty care. By contrast, some beneficiaries cited difficulties with gaining access to mental health providers, and frustration about wait times for appointments among all types of providers. These findings correlate with the experience of many APG member groups, who have especially expressed concern about lack of access to mental health providers in making referrals on behalf of patients.

As more integrated provider groups serve dually eligible beneficiaries, MACPAC's findings emphasize the need for continued monitoring of integrated services to make certain that plans and providers together can deliver on the promises of integrated models. They also underscore the urgency of assuring that beneficiaries have sufficient access to Medicaid services for behavioral health, home and community-based services, and transportation.

The full summary of the study will be included in MACPAC's Report to Congress next summer.

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