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To our subscribers: *Washington Update* is taking a summer break next week. We will be back the following week with our latest update.

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 Board Chair Tells Congress: Move Full Speed Ahead on Value-Based Care

APG Board Chair Anas Daghestani, MD, President and Chief Executive of Austin Regional Clinic, urged members of the House Energy & Commerce Committee's

Oversight and Investigations panel this week to reengineer the Medicare and CHIP Reauthorization Act (MACRA) of 2015 so that it more quickly shifts physicians into value-and-risk-based arrangements.

“Unfortunately, these value-based care models face headwinds that policymakers should address,” Daghestani said during his opening statement. “The current structure of MACRA should be replaced with far greater incentives and possibly mandatory requirements to move to primary care capitation or total risk and global capitation Medicare.” Dr. Daghestani’s full written testimony is here and the full hearing can be viewed here.

During the wide-ranging hearing, Daghestani pressed the importance of providing small and rural providers upfront payments to help defray high infrastructure costs, and regulatory and statutory certainty so that physicians can participate in new payment models with financial stability and sustainability. He and other panelists called for either a major overhaul or complete scrapping of the Merit-based Incentive Payment System (MIPS) track of MACRA, which has slowed the movement to value-based care and lacks the teeth to hold providers accountable for cost and quality.

APG will continue to press the importance of value-based care with Congress as lawmakers look for ways to boost participation in programs that test new ways to pay for high quality patient care.

MedPAC Explores Alternatives for Medicare Advantage Benchmarks

One of several options could replace the current method of setting Medicare Advantage (MA) benchmarks, the Medicare Payment Advisory Commission (MedPAC) says in its newly released June 2023 Report to Congress. Benchmarks are the annual established maximum payments set by the Centers for Medicare & Medicaid Services that MA health plans bid against to provide coverage of Medicare Parts A and B services for Medicare beneficiaries. The benchmark is based on the average per-beneficiary spending for traditional fee-for-service (FFS) Medicare by county, adjusted for geography. If plans bid below the benchmark, as most do, they retain a portion of the difference as a “rebate” that must be used to benefit MA enrollees, such as by adding supplemental benefits. As such, benchmarks and plan bids help to drive some of the fundamental factors that make MA plans attractive to enrollees.

As MedPAC noted in its report, these benchmarks are becoming increasingly problematic as more beneficiaries enroll in MA and the share of Medicare beneficiaries enrolled in FFS declines. For example, if the number of FFS beneficiaries in a county becomes too small, “small changes in enrollment or health service delivery can cause large shifts in average spending” and thus cause large and erratic changes in benchmarks.

To devise a more stable and potentially lower-cost system, MedPAC outlines three alternatives for setting benchmarks: basing them on MA plan bids rather than on spending for FFS beneficiaries; basing them on a blend of both FFS and MA spending; or establishing a baseline benchmark with a fixed annual growth rate. The Commission will discuss these alternatives further and may issue recommendations in the March or June 2024 report.

In its most recent report, MedPAC also reiterated its previous finding that the Medicare program pays about 6 percent more per beneficiary for those who choose MA over FFS – a difference of billions of dollars annually between the two programs. It also repeated its previous finding that one factor in this cost difference is "favorable selection," meaning that enrollees in MA are healthier going into the program than those who remain in traditional Medicare.

APG is creating a research agenda to explore this question further and determine how real the phenomenon is. It will also explore additional options for benchmark alternatives for MA and other Medicare programs. Ultimately, all these issues could affect the future growth and composition of MA plans, as well as the APG groups that today provide care for nearly 10 million MA enrollees.

Keeping Their Care Providers is a Priority for Dual-Eligible Populations Entering Integrated Care Plans

People who are dually eligible for Medicare and Medicaid and have "integrated" coverage of their benefits through a health plan consider the ability to keep their existing primary care doctors, specialists, or health systems as the most important factors in choosing a plan, according to focus groups run on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC.) But as with millions of Americans, integrated plan enrollees face major challenges in accessing mental health providers, experience frequent turnover of these providers within plan networks, and face long wait times, the groups told interviewers. The focus group results are contained in MACPAC's June 2023 Annual Report to Congress.

The analysis comes at a time when both MACPAC and Senate policymakers are pushing greater care integration for the nation's 12.2 million dual eligibles, whose care is often highly fragmented and who achieve poor health outcomes as a result. MACPAC's report notes that there is "substantial variation across states and across programs in terms of the level of integration offered, the types of benefits available, and the performance of the health plans providing the services." Beneficiaries' preferences for being able to keep their existing physician relationships when enrolling with integrated plans could benefit provider groups with strong relationships with these plans, such as D-SNPs (dual-eligible special needs plans, a specific type of Medicare Advantage plan).

APG continues to advocate in Washington on integrated care for duals, sharing with Congress and other policymakers the concerns of member organizations who contract with Medicaid MCOs. Interested APG members can learn more by participating in APG's Medicaid Coalition, which meets monthly. Contact Garrett Eberhardt, APG Executive Director of Medicaid Policy, at geberhardt@apg.org for more information.

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