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## MedPAC's Next Iteration of Alternative Payment Models

Recent meetings of the Medicare Payment Advisory Commission (MedPAC) have provided a glimpse into the next iteration of Medicare alternative payment models (APMs). This Health Capital Topics article will discuss MedPAC's discussion regarding the form such an APM may take, the commission's resulting reactions and recommendations, and what these recommendations may ultimately mean for providers.

MedPAC is an independent congressional agency that advises the U.S. Congress on issues affecting the Medicare program, such as "payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, [as well as] access to care, quality of care, and other issues affecting Medicare."[1] Comprised of 17 members (commissioners) that serve three-year terms, as well as a career staff with "backgrounds in economics, health policy, public health, or medicine,"[2] MedPAC makes recommendations to Congress and to the Secretary of Health and Human Services (HHS).[3] Those recommendations are typically included in one of the two annual reports published by the commission in March and June.

In June 2021, MedPAC recommended that Centers of Medicare & Medicaid Services (CMS) "streamline and harmonize its portfolio of advanced [APMs]."[4] In line with that recommendation, MedPAC began discussing the development of a new multi-track, population-based APM in October 2021, the same month that CMS set a goal for all Medicare beneficiaries to be under a value-based payment arrangement by 2030.[5] In its October meeting, MedPAC commissioners expressed "broad interest in centering CMS's APM strategy around a single multi-track, population-based payment model," with various tracks and financial risk options.[6]

In November 2021, MedPAC commissioners specifically explored developing administratively-set benchmarks for accountable care organizations (ACOs). Historically, ACO benchmarks have been "based on spending for beneficiaries who would've been eligible for the ACO in the baseline years, along with the growth in an ACO's spending between the baseline and performance years."[7] If an ACO comes in below that year's benchmark, they share in those realized savings with Medicare (in some instances, the ACO also shares in the losses if it comes in above the benchmark).[8] This benchmark is reset each year based on the ACO's past performance, meaning that the ACO must perform better each year in order to achieve savings, resulting in benchmarks that become increasingly harder to exceed. This so-called "ratcheting effect" puts long-term ACO participation at risk, as the longer ACOs participate, the smaller the margin is in which to create savings.[9]

In order to address the ratcheting effect, MedPAC proposed during its November 2021 meeting using "an administratively-set trend factor, which could be based on a number of [external] metrics including a discounted projection of Medicare fee-for-service spending growth or projected gross domestic product growth."[10] Certainly, this path has its own issues, such as inaccurate spending projections; random variation in spending, which may "create unwarranted shared savings"; and, other one-time changes by smaller ACOs that may be due to random variation rather than patient care improvements.[11] Additionally, industry stakeholders have questioned the value of such a shift when ACO participation is still voluntary, as it may make administratively-setting benchmarks more difficult.[12] MedPAC's vice chair stated that he "envisions a set up where ACO participation would be mandatory for certain types of providers, with strong incentives in the form of higher fee-for-service rates for other providers to participate as well."[13] However, MedPAC's chair has indicated his aversion to mandatory ACO models and has suggested that ACOs should instead be incentivized to participate.[14]

In its January 2022 meeting, MedPAC staff presented a proposal for a potential three-track APM, (with administratively-set benchmarks using external factors), which tracks would be as follows:

(1) No financial risk track – For independent physician practices, small safety net providers, or rural providers, wherein providers could keep up to 50% of savings generated after meeting a minimum savings rate;
(2) Some financial risk track – For mid-sized organizations (e.g., multispecialty physician practices, small community hospitals), wherein providers could keep up to 75% of savings generated after meeting a minimum savings rate, or repay 75% of losses; and,
(3) Full financial risk track – For large organizations (e.g., health systems with multiple locations), wherein providers would have a 100% shared savings/loss rate.[15]

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Several questions were raised regarding this potential APM, including whether an organization's size is determinate of its ability to take on risk (as smaller organizations are often more nimble), and how soon a provider should have to take on risk (e.g., could small organizations stay in the no financial risk track indefinitely).[16] Other issues that need to be addressed, according to MedPAC commissioners, include how to encourage participation in APMs and setting future dates for mandatory participation (which transparency may provide some certainty to providers as to "where things are going").[17]

The next steps in moving this APM blueprint to reality was not clear from the meeting, although the MedPAC vice chair did state that such APM reform will likely need to be made via legislation.[18] While the agenda for the upcoming MedPAC meeting in March 2022 has not yet been released,[19] providers would be well-served to stay abreast of MedPAC's ultimate recommendations as to the next iteration of value-based care, as they will likely be directly affected by any changes to current programs.

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5. "MedPAC hashes out new alternative payment model strategy" By Maya Goldman, Modern Healthcare, January 14, 2022, https://www.modernhealthcare.com/medicare/medpac-hashes-out-new-alternative-payment-model-strategy (Accessed 1/18/22).
6. "Developing a mulita-track population-based payment model with administratively updated benchmarks" By Rachel Burton, et al., Medicare Payment Advisory Commission, January 14, 2022, available at: https://www.medpac.gov/wp-content/uploads/2021/10/APM-MedPAC-Jan22.pdf (Accessed 1/18/22), p. 2.
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13. *Ibid.*
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