# VALUE IN HEALTH CARE ACT

**(*Section-by-Section*)**

## Section 1:

**Short Title: The Value in Health Care Act**

## Section 2:

### Encouraging participation in the Medicare ACO program.

**Background:** Current Medicare Accountable Care Organization (ACO) program shared savings rates range from 40 to 75 percent. Program changes finalized in late 2018 reduced the shared savings rates for shared savings-only models from 50 to 40 percent. The vast majority of ACOs begin in shared savings-only models before advancing on the path to risk-bearing models, and models need to remain attractive enough to create a pipeline for ACOs to assume risk.

This section would increase Medicare Shared Savings Program (MSSP) BASIC track shared savings rates to at least the following: Basic Levels A and B: 50%; Levels C and D: 55%; Level E: 60%.

### Modifying risk adjustment to appropriate levels.

**Background:** Accurate risk adjustment is imperative to assess ACO performance, as risk adjustment should remove or minimize differences in health and other risk factors that impact performance but are outside the ACO's control. Modest adjustments to the risk adjustment methodology currently used by the Centers for Medicare & Medicaid Services (CMS) would give ACOs a better ability to understand and perform relative to their benchmarks.

This section would update the risk adjustment rules of the MSSP to allow risk adjustment scores to increase at least five percent over a five year agreement period and apply a cap of up to minus five percent on downward adjustments.

### Removing artificial barriers to Medicare ACO program participation.

**Background:** Under the Pathways to Success Final Rule, CMS created a new distinction between "high revenue" and "low revenue" ACOs. These distinctions are arbitrary as written, create an inequitable path, and present disincentives for ACOs who are voluntarily working together to ensure that value-based care succeeds.

This section would eliminate high-low revenue distinction and apply the low revenue policies across all ACOs.

### Ensuring fair and accurate benchmarks

**Background:** The current MSSP benchmarking methodology uses a blend of the ACO's own historical expenditures and expenditure data from the region. However, the regional costs are from all beneficiaries in the ACOs' region, including those assigned to the ACO, which essentially means that the ACO is being measured against its own performance. Under Medicare Advantage (MA), CMS compares the MA plan to fee-for-service beneficiaries for a cleaner comparison. The problem is particularly acute for rural ACOs, where they may be on the only ACO in the region.

This section would modify the MSSP benchmarking methodology to remove ACO beneficiaries from the regional reference population under regional benchmarking (market minus ACO approach).

## Section 3:

### Providing educational and technical support for the Medicare ACO program.

**Background:** The startup costs for ACOs can be prohibitive: investments in clinical and care management, health IT, population analytics, reporting, and administration often cost millions of dollars. CMS previously offered

programs to help fund ACOs up front, with those payments later recouped via shared savings. These programs, such as the ACO Investment Model (AIM), should be reinstated to help ACOs fund activities and transformations to support ACOs' development.

This section would provide advanced funding to ACOs to help them start, or continue, on the path to value.

## Section 4:

### Incentivizing participation in Advanced Alternative Payment Models (Advanced APMs).

**Background:** Eligible clinicians who participate in an Advanced APM and meet certain Qualifying APM Participant (QP) criteria will receive a 5 percent annual lump sum bonus based on performance from 2017 – 2022. Under the current statute, after 2024, that bonus expires and QPs will instead only receive a 0.75 percent increase in Medicare Part B payments. When the Advanced APM bonus expires, many fewer healthcare providers will participate in these advanced, risk-bearing models.

This section would extend the five percent Advanced APM bonus for six additional years, until performance year 2028.

### Correcting the thresholds for participation in an Advanced APM.

**Background:** To become a Qualifying Participant (QP), participants must receive at least 50 percent of their Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM; the payment percentage will rise to 75 percent in performance year 2023. These thresholds are arbitrary and discourage Advanced APM participation and leading to unintended consequences of APM Entities limiting participation of certain providers.

This section would modify the QP thresholds to ensure those participating in Advanced APMs can continue to earn Advanced APM incentive. Specifically, this section beginning in performance year 2023 would allow the Secretary to increase the threshold by no more than 5 percent each performance year to allow for a more gradual and predictable increase.

## Section 5:

### Addressing overlap in value-based care programs.

**Background:** As more APMs are rolled out, APM overlap within markets and provider organizations has occurred more frequently, causing confusion in the marketplace regarding which APMs providers may participate in, and when. While some APMs can complement one another when it comes to improved quality and other outcome-based goals, participation in more than one APM can result in conflicting financial incentives that undermine the objectives of those already in existence.

This section would address APM overlap by requiring the U.S. Department of Health & Human Services (HHS) to review current overlap policies and report back to Congress, require CMS to address overlap in a transparent manner when models are designed and released to the public, and remove the statutory restriction to allow CMS to distribute savings for each program when programs overlap and one of the programs is a temporary program being tested through the Centers for Medicare & Medicaid Services.

## Section 5:

### Addressing Health Equity

**Background:** Providers participating in alternative payment models requires a focus on population health and put these providers in a unique position to address health disparities and work toward health equity.

This section directs the GAO to compare the health outcomes and racial disparities of seniors assigned to an APM versus seniors in regular fee-for-service Medicare. The report focuses on the Medicare Shared Savings Program which is the longest permanently authorized alternative payment model in Medicare.