Value in Health Care Act

Section-by-Section Summary

Section 1: Short Title

Section 2: Encouraging Participation in the Medicare Shared Savings Program.

Removing Barriers to Shared Savings Program Participation. The Centers for Medicare and Medicaid Services (CMS) has a policy that differentiates between "high revenue" and "low revenue" ACOs. Evaluations show that ACOs with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and other safety net providers are typically designated as high revenue ACOs, requiring them to move to risk faster and be ineligible for advance investment payments that support new ACOs. This creates disincentives for including rural and safety net providers in ACOs.

- **This section would eliminate the high-low revenue designation for ACOs.**

Financial Methodology Enhancements to Promote Success of Shared Savings Program. The financial benchmark is the spending target for an ACO's patients. The benchmark is unique to each ACO and based on historical spending, its patient population, and national and regional spending trends. When ACOs spend less than their benchmark, Medicare achieves savings and the ACO is eligible to earn "shared savings." In the CY2023 Medicare Physician Fee Schedule, CMS updated the benchmarking methodology for the Medicare Shared Savings Program (MSSP) to include a prospective growth rate specific to ACOs called the Accountable Care Prospective Trend (ACPT). The change would be effective for new and renewing contracts in 2024. According to a CMS analysis, the ACPT could harm nearly one-third of ACOs.

- **This section establishes guardrails that require CMS to be transparent during benchmark development so that the process can be more easily replicated by stakeholders. It also establishes an appeals and third-party review process to address benchmark disagreements. Lastly, it requires CMS to account for regional variations in spending to prevent arbitrary winners and losers, including setting regional contributions to what it would be without an ACO. This section would also require CMS to report back to Congress within 90 days on the mechanisms the agency can take to avoid penalizing ACOs for changes to the benchmark approach.**

Shared Savings Options. The MSSP is the largest and most successful value-based care program in Medicare and should serve as an innovation platform. As the CMS Innovation Center tests new payment models, successful models or key aspects of those models should be embedded as permanent parts of Medicare via the MSSP, which currently includes various participation options with increasing levels of risk and reward, including Basic Track Levels A–E and the Enhanced Track. However, there is currently no full-risk option for ACOs participating in MSSP, with the highest level of risk at 75 percent of shared savings/losses under the Enhanced Track. A full risk option would allow ACOs to earn up to 100 percent shared savings with the ACO also bearing commensurate risk for any losses, savings accrue to Medicare through a discount on the benchmark.

- **This section directs CMS to establish a voluntary, full-risk option in the MSSP.**

Section 3: Advanced Alternative Payment Model Incentive, Participation, and Threshold Modifications

Extension & Modifications of Alternative Payment Model (APM) Incentives and Thresholds. The Medicare Access and CHIP Reauthorization Act (MACRA) included a 5 percent incentive payment for clinicians to participate in advanced APMs. In 2022, Congress included a one-year, 3.5 percent extension of MACRA's advanced APM incentive payment in the Consolidated Appropriations Act of 2023. Congress also provided a one-year freeze of the qualifying thresholds, which were scheduled to jump from 50 percent to 75 percent. Extending MACRA's advanced APM incentives will help continue to drive participation in advanced APMs while Congress considers long-term reforms to Medicare's physician payment system.

- **This section extends MACRA's 5 percent advanced APM incentive payments for two years to continue to incentivize the movement to value. It also ensures that qualifying thresholds remain attainable and promote program growth by giving CMS the authority to adjust qualifying thresholds through rulemaking and set varying thresholds and scaled incentive payments for more targeted models where participants (i.e., specialists) cannot meet the existing one-size-fits-all thresholds.**

Technical Assistance. While CMS' population health models have seen encouraging growth over the last 10 years, many practices also face challenges transitioning into APMs.

- **This section requires HHS to provide more educational and technical support for ACOs, small practices, specialists, or providers that serve rural or medically underserved populations as they transition into APMs.**

Section 4: Study on Alternative Payment Models and Medicare Advantage

APMs and the Medicare Advantage (MA) program provide opportunities for providers to innovate care and move payments away from fragmented care options to coordinated care that is rewarded for value. It's important to understand how the programs' differences impact care delivery.

- **This section directs the Government Accountability Office (GAO) to evaluate the potential of parity between APMs and MA so policymakers can seek greater alignment between the programs to ensure that both models provide attractive, sustainable options for innovating care delivery, and to ensure that APMs do not face a competitive disadvantage.**