Value in Health Care Act: Improvement to Medicare's ACOs and APMs:

Fiscal Implications

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Over the last several years, many stakeholders seeking to improve the quality of health care while reducing costs and improving health outcomes have focused on the role of Accountable Care Organizations (ACOs) and Alternative Payment Models (APMs). The Affordable Care Act of 2010 (ACA) created a Medicare Shared Savings Program (MSSP) that built on ACO models that had previously been the subject of Medicare demonstration programs and the Centers for Medicare and Medicaid Services (CMS) has implemented a variety of other ACO models as part of its Innovation Center.

Over this period, various stakeholders have raised concerns about the impact of CMS decisions on the willingness of providers to join and maintain membership in various ACO models. As a result, some have pursued legislation that would require changes to various CMS decisions that some stakeholders believe have chilled participation in ACOs.

The Moran Company was asked by our client the National Association of ACOs (NAACOS) to consider the budgetary implications of one such piece of legislation, the Value in Health Care Act of 2021 (H.R. 4587), known as "the Value Act." Specifically, we were asked how the Congressional Budget Office (CBO) might "score" the impact of the bill. This report presents the findings of our analysis.[1]

Highlights of Our Findings

- Our review of CBO's score of the MSSP provisions of the ACA, along with various assessments of the savings achieved by ACOs to date, suggests that the savings that CBO envisioned as possible have not been fully realized thus far.
- The provisions of the Value Act could serve to make ACO participation more attractive to various provider groups, expanding the number of providers that join—and remain part of—ACOs in the future.
- If the Act is successful in expanding provider participation in ACOs, some of the shortfall between the current savings that have been achieved by ACOs and CBO's prior projections could be realized—providing savings that could exceed the cost of increasing shared savings payment rates and other provisions of the Act that serve to increase payments to ACOs.
- At the same time, CMS has already taken steps to close some of the gap between current and projected performance in managing care and reducing cost, reducing the pool of savings available.
- Balancing all of these factors, our net assessment is that the legislation will result in $280 million in savings over the 2022-2031 scoring window.
- We caution, however, that to the extent that CBO believes that savings attributable to ACOs would be achieved without legislation, it could assign costs to some of the provisions of the bill that would offset these savings.

[1] Our analysis was completed using CBO's updated Medicare baseline from July of 2021.

Background on the Value Act

Based on the legislative text we have reviewed, we understand that the bill would require a number of improvements aimed at making ACO participation more attractive. These changes include:

- **Increased Shared Savings Rates for Certain ACOs** of five to ten percentage points relative to the current rates under CMS regulations.
- **Increased Cap on Risk Adjustments.** Current CMS regulations cap potential payment adjustments at 3%. The legislation would increase the cap on positive adjustments to no less than 5%, with negative adjustments of 0% to 5%.
- **Removing Barriers to ACO Participation.** The bill would eliminate distinctions in requirements between low revenue and high revenue ACOs, applying the regulations applicable for low revenue ACOs to all ACOs—while allowing less stringent requirements to be used if the Secretary decides the is appropriate. The bill would also allow participating ACOs to avoid shared losses or two-sided risk before the ACO has participated for at least 3 years in Medicare ACO programs.
- **Making Changes to Benchmarks Used to Measure ACO Performance.** The CMS decision to include ACO beneficiaries in the calculations of regional benchmarks used to measure ACO performance could, in the view of some stakeholders, dilute the value of performance incentives for some ACOs—particularly those in rural areas.
- **Continuing Bonus Payments for Participants in Advanced Alternative Payment Models (APMs).** Under current law, participants in advanced APMs receive a 5% bonus through 2024. In 2026, participants in Advanced APMs that meet certain requirements receive annual payment updates of 0.75%. The legislation would extend the 5% bonus until payment year 2031.
- **Addressing Overlap in Value-Based Care Programs.** The legislation would also require CMS to address potential confusion about overlapping APMs and create provisions to distribute savings for overlapping programs when CMS is testing temporary programs.
- **Other changes designed to encourage participation.** The bill would also make amendments to current statutory requirements to give CMS flexibility to set phase in timelines and other thresholds in ways designed to encourage participation in ACOs and APMs.

Scoring Methodology & Results

CBO's prior score of ACO legislation does not provide details on its views on the impact of particular provisions on its overall score. In our experience, CBO does not always reach independent judgements on the impact of individual provisions in legislation, but rather makes assumptions about the impact of families of policies as a whole.

In approaching the Value Act, we believe that CBO, in addition to considering the impact of additional payments under the Act, might be informed by its prior work and consider the potential pool of additional savings that would be available if the legislation was successful in

encouraging additional organizations to participate in the MSSP or other ACO models being administered by CMS and CMMI. We would also expect CBO to be informed by developments since the creation of the MSSP, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which provided incentives for ACO and APM participation and have been somewhat successful in driving this participation.[2] In particular, we considered the impact of APM bonus payments in helping to incentivize participation. In its a recent final rule, CMS estimated that APM incentive payments for the 2020 performance year would total between $535 million and $685 million.[3] While these payments are significant, we believe that they play a material role in driving participation in the sorts of ACOs likely to realize some of the higher levels of savings that CBO initially expected from the MSSP. If payments were removed, we believe CBO could conclude that many ACO participants might find it rational to shift to the Merit-Based Incentive Payment System (MIPs), reducing the savings that Medicare would otherwise realize from the MSSP. We caution, however, that if CBO believes that ACO participation would be less affected by the reduced bonus payment, they might find the costs of extending bonus payments could exceed the savings that the legislation could otherwise produce.

In building our model of the potential impact of the Value Act we considered the gap between the savings that CBO had originally projected and the savings that have already been achieved by ACOs. The savings that have actually occurred are considered to be already "in the baseline" for budgeting purposes. To quantify the savings that have already been achieved by ACOs, we reviewed a number of studies and CMS analyses of the success of ACOs to date. For example, CMS reported net savings of $739M in 2018 attributable to the MSSP, or approximately 0.1% of total Medicare A&B spending.[4] In addition the direct role of MACRA, we also considered the role of policies that CMS has implemented to attempt to improve the savings achieved by ACOs. In particular, we noted CMS Office of the Actuary (OACT) estimates of the impact of its "Pathways to Success" final rule as potentially creating $2.9B in savings over ten years.[5] We would expect CBO to see these actions as reducing the pool of savings available, and we offset the estimated savings in our model to account for this factor. In addition, the CARES Act modified performance thresholds in 2021 and 2022, reducing the need for incentives to participate during those years.

Below we show the 10-year projected score for the Value Act:

$ in billions	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2022-2031**
Net Change in Direct Federal Spending	$ -	$ (0.02)	$ (0.02)	$ (0.03)	$ (0.03)	$ (0.03)	$ (0.03)	$ (0.03)	$ (0.04)	$ (0.04)	$ (0.28)

[2] See, for example "Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018" *Health Affairs Blog.* https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/

[3] Medicare Calendar Year 2020 Revisions to Payment Policies Under the Physician Fee Schedule. Interim Final Rule. 84 Fed.Reg. 62568 at 62946 (November 15, 2019).

[4] Verma, Seema. Interest In 'Pathways To Success' Grows: 2018 ACO Results Show Trends Supporting Program Redesign Continue (September 30, 2019). https://www.healthaffairs.org/do/10.1377/hblog20190930.702342/full/

[5] Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017; 83 FR 67816; 67824-67825.