Value In Health Care Act of 2020

Section-by-Section Summary

Section 1: Short Title

Section 2: Encouraging participation in the Medicare ACO Program.

a. Increasing shared savings rates for certain ACOs.

Background: Current shared savings rates for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) range from 40 to 75 percent. Program changes finalized in late 2018 reduced 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 restore MSSP BASIC track shared savings rates to at least 50 percent.

b. Modifying risk adjustment to appropriate levels.

Background: Accurate risk adjustment is imperative to assessing ACO performance and 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 used by the Centers for Medicare & Medicaid Services (CMS) would give ACOs a better ability to understand and perform relative to their benchmarks. The current risk adjustment cap is 3 percent over a five-year agreement, which is unreasonably low especially as COVID-19 may cause unpredicted spikes in risk scores.

This section would update MSSP risk adjustment so that, over the course of a five-year agreement period, positive risk score increases would be subject to a cap of no less than 5 percent and negative risk score adjustments would be between 0 and negative 5 percent.

c. Removing artificial barriers to Medicare ACO program participation.

Background: Under the 2018 Pathways to Success Final Rule, CMS created a new distinction between "high revenue" and "low revenue" ACOs. This distinction is arbitrary as written, creates an inequitable path, and presents disincentives for ACOs who are voluntarily working together to ensure that value-based care succeeds. High revenue ACOs are forced to assume higher levels of risk more quickly.

This section would eliminate the high-low revenue distinction and apply the low revenue policies across ACOs. It would also provide ACOs at least three years in shared savings-only models and make the Enhanced track voluntary.

d. 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. This essentially means the ACO is being compared 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, with the conditions and amounts up to the discretion of the Secretary, and funds recouped through shared savings.

Section 4: Incentivizing participation in Advanced Alternative Payment Models (Advanced APMs).

a. Extending the Advanced APM incentive payment.

Background: Eligible clinicians who participate in an Advanced APM and meet certain Qualifying APM Participant (QP) criteria receive a 5 percent annual 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, fewer healthcare providers will participate in these advanced, risk-bearing models. Participation in Advanced APMs has fallen short of expectations for a number of reasons, such as a limited number of qualifying models. More time and incentives are needed to achieve the original goal of substantially shifting Medicare payments to value.

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

Correcting the thresholds for participation in an Advanced APM.

Background: To become a QP, clinicians 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; these percentages will rise to 75 percent and 50 percent respectively in performance year 2021. The most recent CMS data shows clinicians are not meeting these thresholds, which are too high and are discouraging Advanced APM participation and leading to unintended consequences of APM Entities limiting participation by 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 would set the payment threshold at 50 percent in 2021 and limit the Secretary to increase the threshold by no more than 5 percent each performance year thereafter.

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 CMS.