ALLIANCE FOR VALUE-BASED PATIENT CARE

The Value in Health Care Act

The Value in Health Care Act is a bipartisan bill introduced by Reps. Darin LaHood (R-IL), Suzan DelBene (D-WA), Brad Wenstrup (R-OH), Earl Blumenauer (D-OR), Larry Bucshon (R-IN), and Kim Schrier (D-WA) that makes several important reforms to ensure that alternative payment models (APMs) continue to provide high-quality care for Medicare beneficiaries. In the last decade, APMs have generated billions of dollars in savings for taxpayers all while maintaining high quality for patients. A key aim of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) was to speed the transition to patient-centered, value-based care by encouraging physicians and other clinicians to transition into APMs. While MACRA was a step in the right direction, more needs to be done to drive long-term system transformations. The Value in Health Care Act helps maintain and further strengthen the movement towards value where financial performance is linked to the quality of patient care rather than the number of services delivered.

Bill Summary

Extends Value-Based Care Incentives. Appropriate financial incentives help attract physicians and other clinicians to participate in advanced APMs and reward those that continue to engage in value. In 2022, Congress included a 12-month extension of MACRA's advanced APM incentive payment in the Consolidated Appropriations Act of 2023. While this short-term extension ensures that the nearly 300,000 physicians and other clinicians working to improve the quality and cost-effectiveness of care continue to have the financial resources to do so, it will expire at the end of 2023.

- ✓ Provides a multi-year commitment to reforming care delivery by extending MACRA's 5 percent advanced APM incentive payments for 2 years to continue to encourage the movement to value.
- ✓ Ensures that qualifying thresholds remain attainable to promote program growth by giving the Centers for Medicare & Medicaid Services (CMS) authority to adjust qualifying thresholds through rulemaking and set varying thresholds for more targeted models where participants (i.e., specialists) cannot meet the existing one-size-fits-all thresholds.

Ensures Participants Join and Remain in Existing APMs. Current and past APMs have allowed physicians and other clinicians to change care delivery and improve care coordination. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care.

- ✓ Removes the revenue-based designation in the Medicare Shared Savings Program (MSSP) that penalizes certain ACOs, especially those including rural and safety net providers.
- ✓ Establishes guardrails for CMS to ensure that the process to set financial benchmarks is transparent and appropriately accounts for regional variations in spending to prevent arbitrary winners and losers.
- ✓ Directs CMS to establish a voluntary, full-risk track within programs like the MSSP and has HHS provide more technical assistance to new APM participants.

Evaluates Parity Between APM and Medicare Advantage (MA) Program Requirements. APMs and the MA program provide opportunity for physicians and other clinicians to innovate care and move payments away from fragmented care options to coordinated care that is rewarded for value. We must understand how the programs' differences impact care delivery.

- ✓ 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.

For more information, or to sign on as a cosponsor, contact Austin Welter (austin.welter@mail.house.gov) with Rep. Darin LaHood or Abe Friedman (abe.friedman@mail.house.gov) with Rep. Suzan DelBene.