The Value in Health Care

The Value in Health Care Act is a bipartisan bill that Reps. Darrin LaHood (R-IL) and Suzan DelBene (D-WA) will be introducing in 2023 to help grow participation and drive innovation across Medicare's value-based care programs. Value-based payment reforms have a long history of bipartisan support which has generated over $17 billion in gross savings for Medicare over the last decade and improved the quality of care for millions of 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 alternative payment models (APMs). Today, approximately 30 percent of Medicare clinicians are participating in risk-based payment models, but the rate of uptake remains below original projections. 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 is the next step.

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 move forward on their value transitions. 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 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 incent 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 high-low revenue designation in the Medicare Shared Savings Program (MSSP) that penalizes certain ACOs, especially safety net providers like Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).
- ✓ 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 winners and losers.
- ✓ Directs CMS to establish a voluntary full-risk track within programs like the MSSP.
- ✓ Allows CMS to provide more technical assistance to new APMs.

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

- ✓ Directs the Government Accountability Office (GAO) to evaluate 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.