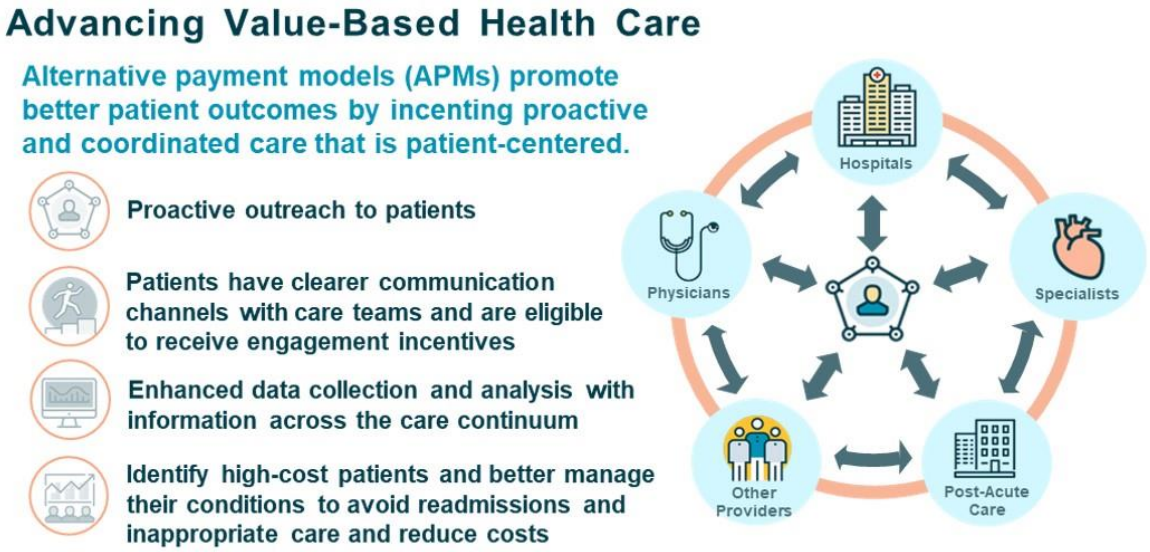
Support the Value in Health Care Act of 2023 (H.R. 5013)

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)

Rising healthcare costs coupled with labor shortages and an aging population underscore the need for innovation and the continued movement towards value-based care. Medicare must move towards a system that supports quality and coordination of patient care rather than the number of services delivered. To innovate, healthcare providers must invest in quality measurement and improvement, patient-centered care and advanced technologies that facilitate knowledge sharing and care coordination.

The past decade has seen significant advances as more physicians and other clinicians transition into alternative payment models (APMs). **APMs have generated billions of dollars in savings for Medicare while maintaining high-quality care for patients.**[i] While much has been achieved, more needs to be done to drive long-term system transformation.



The Value in Health Care Act (H.R. 5013) is a comprehensive approach that will strengthen the Medicare program and ensure high quality care for Medicare beneficiaries. Specifically, the bill:

- ✓ **Extends MACRA incentive payments for two years**
  - The bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) established incentive payments for providers who take on increased financial risk through Advanced APMs. These payments have been critical to increasing participation in APMs as they help clinicians to cover the investment costs of moving to new payment models, as well as to stabilize revenues as they move from fee-for-service.
  - Calendar year 2023 is currently the last year that clinicians can qualify for these payments. H.R. 5013 provides a multi-year commitment to reforming care delivery by extending MACRA's 5 percent advanced APM incentives for an additional two years.

- ✓ **Modifies the thresholds to qualify for advanced APM incentive payments to better reflect progress in value-based care**
  - MACRA established performance thresholds - known as Qualifying APM Participant (QP) thresholds - that APM participants must meet to qualify for incentive payments. These statutory levels, which increase over time, have proven unrealistic relative to the real-life experiences of providers.

- Congress has previously adjusted the QP thresholds to align with the real-life experiences of providers. The Value in Health Care Act would likewise give CMS authority to adjust the QP thresholds so that the current one-size-fits-all approach does not serve as a disincentive to including rural, underserved, primary care or specialty practices in APMs.

✓ **Ensures all providers have equal opportunity to participate by removing arbitrary Medicare Shared Savings Program (MSSP) distinctions**
- Several years ago, CMS began varying MSSP policies based on an ACO's revenue status under the false premise that low-revenue ACOs (i.e., physician-led) outperform high-revenue ACOs (i.e., hospital-led).
- This distinction has led some ACOs to avoid partnering with certain provider types, such as hospitals or specialists, and have disadvantaged rural and safety net providers.
- A recent Premier analysis found that differences between high- and low-revenue ACOs are driven by other factors beyond ACO composition, including geographic location and the types of beneficiaries attributed to ACOs.
- H.R. 5013 eliminates these revenue-based distinctions, ensuring that high performers are encouraged to participate regardless of provider type and allowing providers to more effectively collaborate in ways that best meet the needs of their patients.

✓ **Establishes fair and accurate benchmarks by ensuring ACOs are not competing against themselves**
- Current benchmarking approaches, which are based on a participant's historical experience, set-up an unsustainable scenario whereby ACOs are competing against themselves and must continue to achieve year-over-year savings.
- H.R. 5013 improves financial benchmarks so that ACOs are not penalized for their own success.

✓ **Establishes a voluntary track for ACOs in the MSSP to take on higher levels of risk and provides technical assistance for clinicians new to APMs.**
- This will allow more clinicians to continue the transition to value.

✓ **Calls for studies to increase alignment between APMs and Medicare Advantage (MA) that will ease burdens on providers and ensure that both APMs and MA are attractive and sustainable options.**

The Value in Health Care Act is supported by a broad range of stakeholders, including: Accountable for Health, American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American College of Physicians, American Hospital Association, American Medical Association, America's Essential Hospitals, America's Physician Groups, AMGA, Association of American Medical Colleges, Federation of American Hospitals, Healthcare Leadership Council, Health Care Transformation Task Force, Medical Group Management Association, National Association of ACOs, National Rural Health Association, as well as Premier.

Premier urges lawmakers to cosponsor the Value in Health Care Act (H.R. 5013)

For more information, contact John Knapp, Vice President of Advocacy, at john_knapp@premierinc.com

[i] https://valuebasedcare.org/avbpc-value-101/ (slides 8, 9)