MILLIMAN WHITE PAPER

Value in HealthCare Act of 2020: A sign of things to come?

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On July 24, 2020, a bipartisan bill entitled "Value in HealthCare Act of 2020"[1] (VHCA) was introduced to the U.S. House of Representatives proposing a number of significant changes to the Centers for Medicare and Medicaid Services (CMS) Medicare Shared Savings Program (MSSP) and the Advanced Alternative Payment Model (APM) feature of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Given the timing of the introduction of this bill (less than six months before an election and in the midst of the COVID-19 pandemic), there is uncertainty about whether (or when) the bill will be passed into law (or voted on). However, the introduction of it is a significant step towards encouraging value-based care and signifies an appetite for change in the MSSP in order to encourage additional participation of Accountable Care Organizations (ACOs). This paper will discuss the proposed changes included in this bill as well as the implications of each change on ACOs, in particular those under the Pathways to Success model.[2]

Proposed changes to MSSP

VHCA includes a number of changes to the CMS methodology of the MSSP program that makes the program more attractive to potential participants and increases the likelihood of current participants continuing in the program.

INCREASED SHARED SAVINGS RATES

The bill would increase the shared savings rates for each level of the BASIC program under Pathways to Success. This would mean increasing the shared savings rate for Levels A and B from 40% to 50%, for Levels C and D from 50% to 55%, and for Level E from 50% to 60%.

Increasing shared savings rates make the Pathways to Success model more attractive to current MSSP Track 1 participants, who may be hesitant about taking downside risk. Under the current parameters, Levels A and B (no downside risk) have lower shared savings rates (40%) than Track 1 (no downside risk) had under the previous MSSP methodology (50%). This change brings Levels A and B in line with Track 1, which would make the transition to Pathways to Success more attractive for ACOs (new or continuing) that may be reluctant to participate, while retaining current incentives for plans to continue on the progression to a two-sided risk model.

INCREASE MAXIMUM RISK ADJUSTMENT TO +5%

VHCA would replace the current cap of +3% on positive risk adjustment between the third baseline year and the performance year with a +5% cap. Additionally, the bill would introduce a -5% floor on the risk adjustment.

Given the extended agreement period under Pathways to Success (five years) many ACOs expressed concern over the +3% risk adjustment cap. An increase to +5% allows greater variation in population risk to be captured within the program parameters and may give ACOs a greater opportunity to generate savings through improved coding patterns, while the -5% floor provides ACOs with some certainty as to how low their benchmark may go.

ELIMINATE PROSPECTIVE DISTINCTIONS BETWEEN HIGH-REVENUE AND LOW-REVENUE ACOS

Currently, high-revenue and low-revenue ACOs face different requirements under MSSP.[3] Of note, experienced high-revenue ACOs must enter the program in the ENHANCED track while experienced low-revenue ACOs have the option of entering the program at BASIC, Level E. Additionally, the current rules allow inexperienced low-revenue ACOs to remain in BASIC, Level B (no downside risk), for an additional year if they agree to transition to BASIC, Level E, for the remainder of their agreement periods (typically two years).

[1] The text of the full bill is available at https://delbene.house.gov/uploadedfiles/the_value_in_health_care_act.pdf.

[2] For more information on Pathways to Success, refer to https://www.milliman.com/en/insight/mssp-the-series.

[3] For definitions of high-revenue and low-revenue ACOs see: NAACOS Assessment of High-Low Revenue Designations. Retrieved on September 3, 2020, from: https://www.naacos.com/naacos-assessment-of-high-low-revenue-designations.

This bill would practically eliminate the distinction between high-revenue and low-revenue ACOs and standardize the requirements to those currently in place for low-revenue ACOs. The bill also explicitly states that any provisions that would require an ACO to take downside risk before participating in the program for at least three years will be removed.

The main impact of this change will be that all ACOs will be able to have upside-only risk sharing for up to three years and high-revenue, experienced ACOs would be able to enter the program at BASIC, Level E, as opposed to ENHANCED. While the implications of requiring three years of upside-only risk is unclear, one interpretation would be that BASIC, Level C, would become upside-risk only. Alternatively, it could also mean that ACOs will be allowed to remain in BASIC, Level A, or BASIC, Level B, for an additional year. This feature makes the MSSP program more attractive to ACOs that were hesitant to join due to potential downside risk exposure.

REGIONAL BENCHMARK CALCULATION UPDATE

The bill would remove members currently assigned to any ACO from the calculations in setting the regional benchmarks.

This change would affect both the regional trend and regional adjustment calculations. While many ACOs see this change as a positive one, there are a number of complications that arise with the proposed methodology that require further clarification from CMS. These complications include, but are not limited to the following:

1. If a region has a high density of ACOs (such as many large urban areas), then it is possible that only a small proportion of attributable lives in the region will be included in the regional cost and trend. CMS may need to account for this with some sort of credibility adjustment for lower volume regions.
2. CMS currently applies a blended national/regional trend to the benchmark under Pathways to Success based on an ACO's regional penetration rate. However, the proposed change to the calculation of the regional expenditures and trends will make this adjustment duplicative and may require refinement.
3. The bill does not state whether the regional costs in prior years (benchmark years) would be restated to remove all beneficiaries assigned to current ACOs or if only beneficiaries assigned in performance years are removed.

One of the most notable features of the MSSP is that so much of the program's structure is determined by regulation, and is not specified in the Social Security Act. By fixing certain provisions of the MSSP in statute, Congress would be constraining the design of the program. This would provide some small degree of certainty on program structure to current and prospective ACOs, but also put material constraints on HHS' ability to modify the future structure of the MSSP as they did in the "Pathways to Success" rule.

Proposed changes to Advanced APM

Along with changes to the MSSP methodology, the bill includes a number of changes to the Advanced APM qualification standards that incentivize providers to adopt alternative payment models (including MSSP).

EXTENSION OF 5% BONUS

The Advanced APM bonus, which is a 5% incentive payment on Part B expenditures if an organization meets certain payment and patient threshold score requirements relating to taking downside risk, is set to expire in 2024. If the bill is adopted, the bonuses will instead be in effect through 2030.

The proposed change would continue to encourage providers to invest in alternative payment models and further incentivize ACOs to take on downside risk.

RESTRICTION OF ADVANCED APM THRESHOLD INCREASES

Under the current model, an ACO must receive at least 50% of its Medicare Part B payments or see at least 35% of Medicare patients through an Advanced APM entity to qualify as an Advanced APM. However, starting in the 2023 payment year (based on 2021 performance), the thresholds are currently scheduled to increase to 75% of payments and 50% of patients. The bill would impose a restriction limiting the increase of the payment percentage threshold to 5% over the prior year—thus reducing the potential threshold for the 2023 payment year.

About one-third of current ACOs that have met the Advanced APM requirements in 2019 would struggle to meet the 75% payment requirement in 2021. This change would allow about half of the at-risk ACOs to retain their Advanced APM status through 2021 and increase their likelihood of remaining in the MSSP program.[4]

[4] Byron, D. & Smith, C. (July 2020). Raise the Bar: How to Achieve QP Status During a Pandemic. Milliman White Paper. Retrieved on August 28, 2020, from https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/raise-the-bar-how-to-achieve-qp.ashx.

Conclusion

The introduction of the MSSP Pathways to Success rule has led to a decrease in interest from ACOs looking to participate in MSSP.[5] However, the adoption of the Value in HealthCare Act of 2020 could encourage increased participation in the program through a number of methodological changes that make the program potentially more attractive to participants.

[5] Castellucci, M. (January 2020). Participants continue to drop out of Medicare ACO program. Modern Healthcare. Retrieved on August 28, 2020, from https://www.modernhealthcare.com/government/participants-continue-drop-out-medicare-aco-program.

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