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BEYOND THE NUMBERS

# Considerations in MSSP vs ACO REACH Participation

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# Outline

- Recent Success in MSSP vs ACO REACH
- Key Model Differences and Decision Factors
- Proposed MSSP Model Changes

# Recent Success in MSSP vs ACO REACH

| Model | Performance Year | ACO/DCE Count | Average Aligned Benes Across All ACOs/DCEs | Average Gross Savings (Reduction in Spending Compared to Benchmark) |
|---|---|---|---|---|
| MSSP | PY 2022 | 483 | 11.0 million | 3.70% |
| MSSP | PY 2023 | 453 | 10.2 million | 3.90% |
| MSSP | PY 2024 | 480 | 10.8 million | TBD |
| GPDC / ACO REACH | PY 2022 | 99 | 1.9 million | 3.70% |
| ACO REACH | PY 2023 | 132 | 2.1 million | 5.90% |
| ACO REACH | PY2024 | 115 | 2.4 million | 5.50% |

- Both MSSP and ACO REACH have experienced success – no universally "better" program
- Participation in ACO REACH has grown quickly; MSSP participation increases in 2024 after slowdown
- ACO REACH will reward high performing groups through higher savings rates, advanced payments, and flexibility – comes at cost of higher risk
- Additional CMMI flexibility to improve ACO REACH program over model performance period

*Sources:*
*https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results*
*https://www.cms.gov/priorities/innovation/media/document/aco-reach-gpdc-quarterly-transp-report*

***ACO REACH Keys to Profitability:***

- *Ability to manage medical expense trend below national trend rates*
- *Ability to code patients' diagnoses to combat risk score normalization and coding intensity adjustments*

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# Key Model Differences and Decision Factors

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- Benchmark Methodology
- Risk Adjustment
- Expenditures and Shared Savings
- Provider Payment Mechanisms
- Benefit Enhancements
- Quality

# Benchmark Methodology

| Key Differences | | Implications |
|---|---|---|
| Historical Baseline Expenditures | **ACO REACH** – fixed baseline years of 2017-2019; 10/30/60 weighting on each year. Starting in 2025, voluntarily aligned members will have baseline years of 2021-2023<br>**MSSP** –3 years prior to start of agreement period; 10/30/60 for first agreement period than equal weight | • Benchmarks under both programs will be highly dependent on performance in baseline years<br>• COVID will influence MSSP benchmark more significantly if MSSP baseline years span 2020 and 2021<br>• MSSP may be more subject to "ratcheting" effect if baseline years span more recent time periods |
| Benchmark Trend | **ACO REACH** – Adjusted USPCC prospective trend<br>**MSSP** –1/3 USPCC prospective trend and 2/3 national / regional blend. | • By using a prospective, national trend factor, ACO REACH entities may be less subject to the "rural glitch" that can occur in MSSP as a result of an ACO's own beneficiaries on regional expenditures when calculating the benchmark<br>• Prospective trend factors give ACOs participating in REACH a more defined medical expense target to hit and track against |
| Regional Adjustments | **ACO REACH** – Utilizes a county-level ratebook based on National ACO REACH Reference Population; asymmetric regional cap at +5% / -2%<br>**MSSP** – calculated based on assignable beneficiary population over 1-year period; currently has symmetric 5% regional cap, with 0% cap on downside | • ACO REACH ratebook will have lower volatility than MSSP regional rates (uses credibility adjusted 3-year average vs one base year under MSSP)<br>• Preliminary analyses have found ACO REACH program to have, on average, higher regional benchmark compared to MSSP, but this is highly specific to the ACOs service area[1] |

[1]*Source: NAACOS MSSP vs ACO REACH Webinar; 8/23/2022*

# Benchmark Methodology (cont.)

| Key Differences | | Implications |
|---|---|---|
| Health Equity Adjustment | **ACO REACH** – positive or negative adjustment to benchmark based on Area Deprivation Index and Dual population served (as currently proposed)<br>**MSSP** – up to 10 bonus points to the quality performance score for ACOs delivering high quality care to underserved populations | • The impact to the benchmark for health equity adjustments has been modeled by several groups to be relatively insignificant<br>• Health equity adjustment should not play a major role in the decision to participate in ACO REACH vs MSSP |
| Global Discount | **ACO REACH** – Reduces benchmark in Global option by 3% in 2024 and 3.5% in 2025 and 2026 as a means for CMS to share in savings; No discount factor for professional option<br>**MSSP** – No discount applicable to MSSP but savings are capped | • Implication is not as simple as REACH benchmark equals MSSP benchmark minus 3% / 3.5%<br>• CMS and NAACOS have supported that many other factors influence benchmark under these programs, and only looking at the discount factor is an oversimplification of program dynamics |
| Retrospective Trend Adjustment | **ACO REACH** – Adjustment to benchmark if observed PY expenditures for ACO REACH National Reference population diverges significantly from prospective USPCC growth trend<br>**MSSP** – NA: MSSP benchmark update factors are currently retrospective | • National retrospective trend may not apply well to specific REACH ACO or service area<br>• Retro trend adjustment has complicated financial projections under ACO REACH<br>• Retro trend adjustment should subside in later years of model as we move further away from pandemic |

# Expenditures and Shared Savings

## Key Considerations

- REACH Global option shares 100% of first dollar savings vs 40%-75% in MSSP (for enhanced options)
  - Performance improvements in REACH will pay off more, dollar for dollar, than MSSP (and vice versa for losses) – more risk, more reward
- Consider the group's history and ability to manage medical trend below national trend rates
  - Groups will generally be well-positioned to be profitable under ACO REACH if they are able to maintain risk score coding to keep up with CIF and Normalization factors, and manage medical expenditure trend below national rates
- Consider whether presence of capitation will produce lower expenditure trends than if paid on FFS basis
  - Early indications have shown that expenditures for services under capitation are about 10% lower than what they otherwise would have been under FFS reimbursement
- MSSP has options for Minimum Savings Rate / Minimum Loss Rate –
  - Can provide downside protection but make savings more difficult to realize

| ACO REACH - Shared Savings Parameters | | | | |
|---|---|---|---|---|
| | Global | | Professional | |
| Corridors | % of Benchmark | Savings / Losses Rate | % of Benchmark | Savings / Losses Rate |
| Risk Corridor 1 | 0% | 100% | 0% | 50% |
| Risk Corridor 2 | 25% | 50% | 5% | 35% |
| Risk Corridor 3 | 35% | 25% | 10% | 15% |
| Risk Corridor 4 | 50% | 10% | 15% | 5% |

| Expenditures Under Presence of Capitation | | | |
|---|---|---|---|
| Period Covered | DCE Count | Average % of Performance Year Benchmark paid via Capitation | Preliminary % of capitation payments spent on Medicare Covered Services |
| Apr-Dec 2021 | 36 | 2.5% | 90.8% |
| Jan-Dec 2022 | 99 | 2.9% | 95.5% |
| Jan-Dec 2023 | 132 | 3.4% | 95.5% |

*Source: https://www.cms.gov/priorities/innovation/media/document/aco-reach-gpdc-quarterly-transp-report*

# Provider Payment Mechanisms

## Key Considerations

- Capitation arrangements
  - Mandatory in ACO REACH
  - MSSP providers are paid only via FFS, unless able to participate in Primary Care Flex (low revenue ACOs)
- Capitation payments are made directly to the ACO REACH entity
  - Consider what administrative capabilities ACO has to distribute to providers
  - Offers flexibility for unique reimbursement models or provider incentives depending on sophistication of ACO
- Capitation payments provide a cash flow mechanism to invest in capabilities required to succeed in value-based payment models:
  - Provides flexibility and funding to support investments in higher touch care coordination, meaningful interventions, and ways to reduce burden on providers
- Consider whether capitation is attractive to your participant providers

**Capitation Elections in GPDC/REACH**

| Payment Mechanism | 2021 Election %'s | 2022 DCE Election %'s |
|---|---|---|
| No Capitation | 32% | 0% |
| Primary Care Cap (PCC) | 47% | 73% |
| Advanced Payment Option (APO) | 12% | 19% |
| Total Care Cap (TCC) | 21% | 27% |

*Source: NAACOS MSSP vs ACO REACH Webinar; 8/23/2022*

***Enhanced PCC:***

*ACO REACH PCC includes an "Enhanced PCC" which functions as an interest-free loan from CMS during Performance Year*

***APO:***

*The APO can be a powerful cash flow mechanism to receive advanced payments on non-primary care services with no impact to shared savings or losses*

# Risk Adjustment

## Risk Score Considerations

- Risk Score Cap – both programs implement a version of a 3% cap on normalized risk score improvement during the performance period
  - MSSP risk score cap is tied to improvements in HCC risk scores relative to BY3, whereas ACO REACH will adopt a static reference year population (2022) to which risk score improvements (or deteriorations) are measured against. Consider what BY3 risk scores look like under MSSP
  - MSSP does not implement a floor on any risk score deterioration relative to BY3, whereas ACO REACH implements a symmetric 3% cap/floor. Floor provides protection against risk score deterioration
  - ACO REACH will apply the 3% risk score cap/floor relative to the change in the demographic risk score. The 3% cap was finalized for MSSP in 2024. Protects against increases in demographic risk of patient population (i.e. dual, disabled, etc.)
  - Starting 2024, MSSP risk ratio cap will be applied to the regional risk score as well, eliminating the overall negative regional adjustment to the benchmark to encourage participation by ACOs caring for medically complex, high-cost beneficiaries
- V28 Risk Adjustment Model
  - Phasing in at 1/3 weight in PY 2024 for ACO REACH. Expected to be 2/3 in PY 2025 and 100% in PY 2026
  - For new agreement periods starting in 2024, v28 will be phased 1/3 each year from 2024-2026 for both the performance year and the benchmark years
- Coding Intensity Factor (CIF)
  - ACO REACH applies a model-wide retrospective (CIF) to ensure normalized and capped risk scores across the entire ACO REACH model do not increase relative to 2019. REACH participants will need to maintain coding ability relative to peers in model to avoid savings deterioration

# Benefit Enhancements

| Benefit Enhancements Available Under MSSP and ACO REACH | | |
|---|---|---|
| **Benefit Enhancement** | **MSSP** | **ACO REACH** |
| 3-Day SNF Waiver | Y | Y |
| Telehealth | Y | Y |
| Post Discharge Home Health Visits | N | Y |
| Care Management Home Visits | N | Y |
| Homebound Home Health Waiver | N | Y |
| Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit | N | Y |
| Part B Cost Sharing Support | N | Y |
| In-kind Incentives | N | Y |
| Chronic Disease Management Program | N | Y |
| Nurse Practitioner Services Benefit Enhancement | N | Y |

*Sources: https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa*

- ACO REACH provides more options and greater flexibility for benefit enhancements as compared to MSSP
- Benefit enhancement elections have varied in popularity amongst existing REACH ACOs

# Quality

## Key Differences and Considerations

- ACO REACH applies a 2% quality withhold amount from the benchmark that can be earned back through performance on quality measures
- ACO REACH also introduces a “High Performers Pool”, where ACOs that demonstrate a high level of performance or meet improvement criteria may receive additional bonuses that are funded from quality withholds not earned back by other ACOs
- Consider recent operational concerns regarding reporting via electronic clinical quality measures (eCQMs) under MSSP. eCQMs are required in 2024.
  - ACO REACH may be less administratively burdensome in this area
- MSSP Proposed Rule seeking comment on incorporating health equity and SDOH into quality measurement

# MSSP Recent Changes

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## Key Changes

- Financial Methodology – *most changes starting 1/1/24*
  - Changes were focused on ways to encourage participation and retention of ACOs, ways to ensure rebased benchmarks do not punish prior ACO performance, and methods to address the impact of an ACO's own beneficiaries on regional factors that influence the benchmark
  - Proposal to add a **National Prospective trend** when updating historical benchmarks to performance year. Would be added in addition (with 1/3 weight) to existing retrospective National/Regional 2-way blend.
  - **Reductions to the impact of negative regional adjustments** – addresses participation concerns, particularly for ACOs that serve high-cost, medically complex patients
  - **Adjusting ACO benchmarks to account for prior savings** – addresses "ratchet" effect when prior savings penalize benchmarks
  - **Risk adjustment** revisions that would apply risk score growth caps relative to changes in demographic risk scores and calculate risk score cap at aggregated level (as opposed to each enrollment type)
- Quality Changes – reverting to sliding scale for shared savings / losses; health equity proposal
- Participation changes – Advance Investment Payments (AIP) and slowing transition to risk
- PC Flex options for AIP and capitation for primary care services
- Other – efforts to reduce administrative burden

# Making A Decision

## MSSP vs ACO REACH

Jim Scott, Vice President of Underwriting

# MSSP vs ACO REACH Decision Points

| ACOs Well-Suited For ACO REACH | ACOs Well-Suited For MSSP |
|---|---|
| Reduced Utilization Patterns Post-COVID | More efficient risk-adjusted cost of care compared to others in the region |
| Strong relationships with potential downstream entities (SNFs, Rehab facilities, Urgent Care clinics, etc.) | Short-term plan to improve the accuracy of documentation and coding |
| Willingness to curate participating providers at the NPI level | Recent historical success in MSSP |

- While ACO REACH and MSSP have many similarities, the profile characteristics of a given ACO will likely favor one option over the other