Medicare Advantage MCOs, meet ACOs. You should talk.

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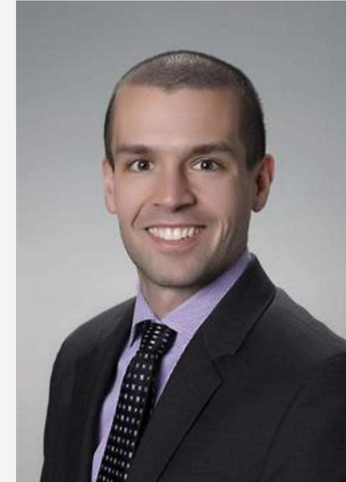

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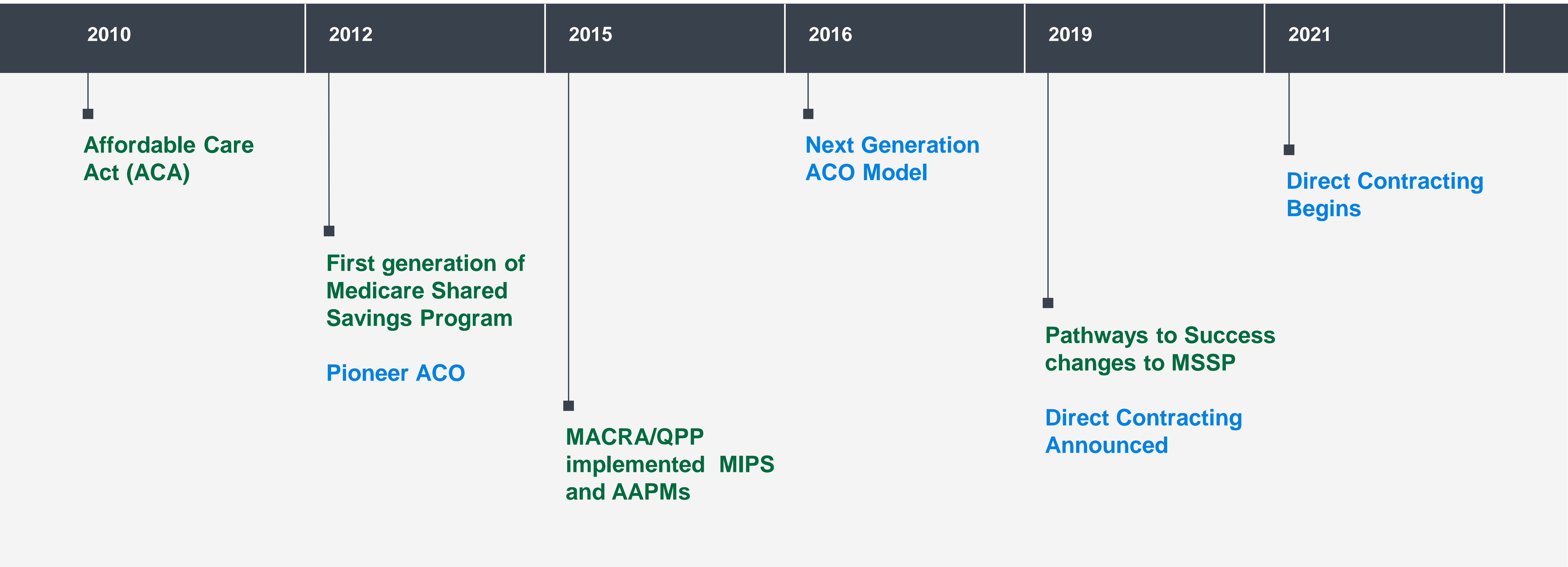
Evolution of CMS programs

- The Affordable Care Act (ACA) contained reforms targeting how healthcare is delivered in the United States. Among other things, one of the goals of the ACA was to **shift reimbursement from volume to value**.
- CMS and CMMI have operated various population-based payment models allowing organizations to take financial risk for Medicare FFS patients.
- The move to value-based payments requires provider organizations:
  - to collaborate across the continuum of care.
  - to bear financial risk for episodes and populations.
  - to engage more proactively with patients.

CMS innovation timeline



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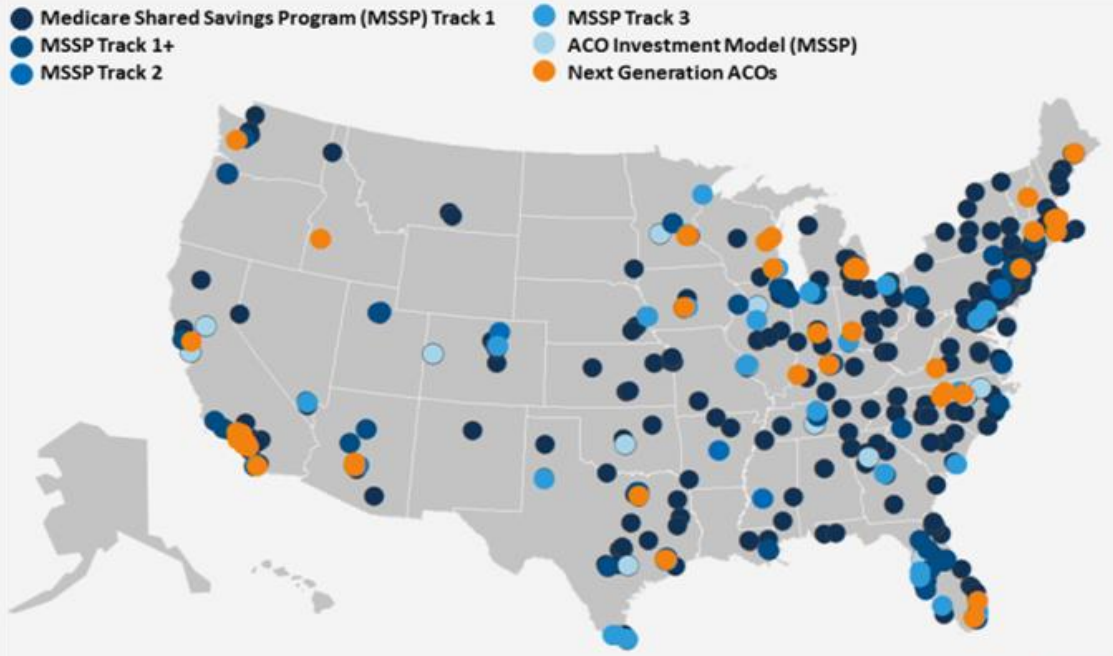
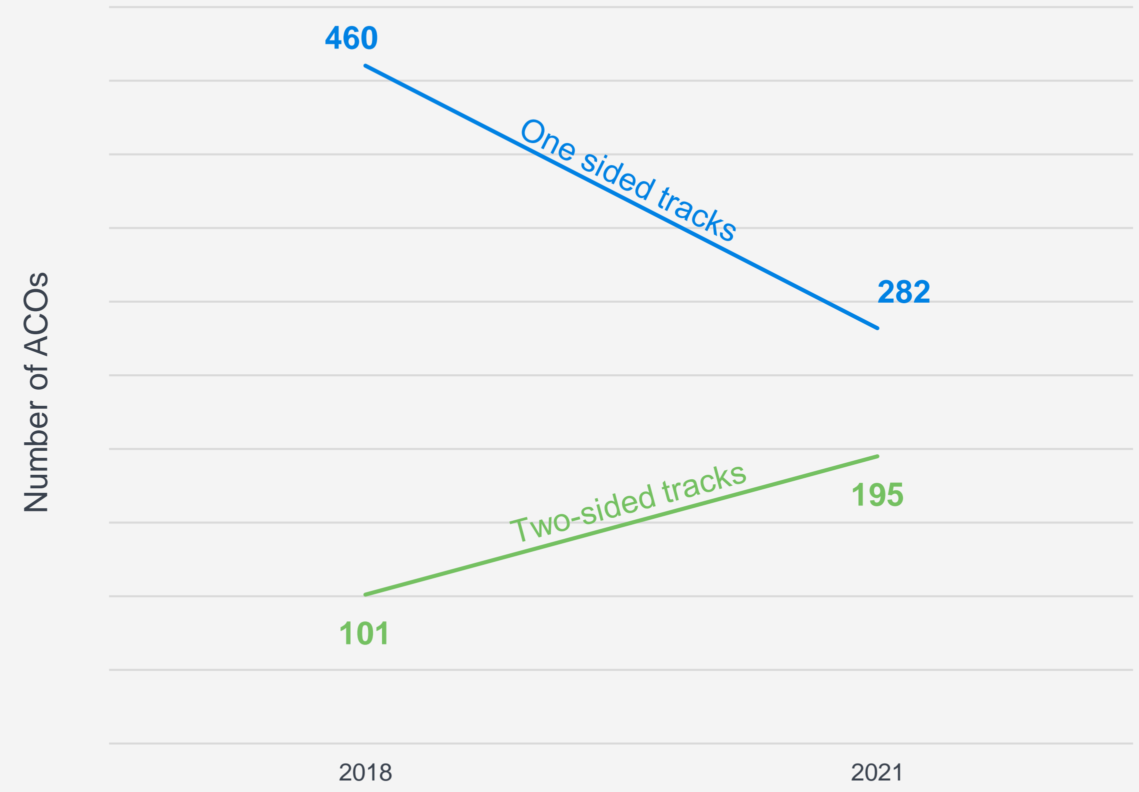
Current ACO landscape

Accountable Care Organization (ACO) models (2018)



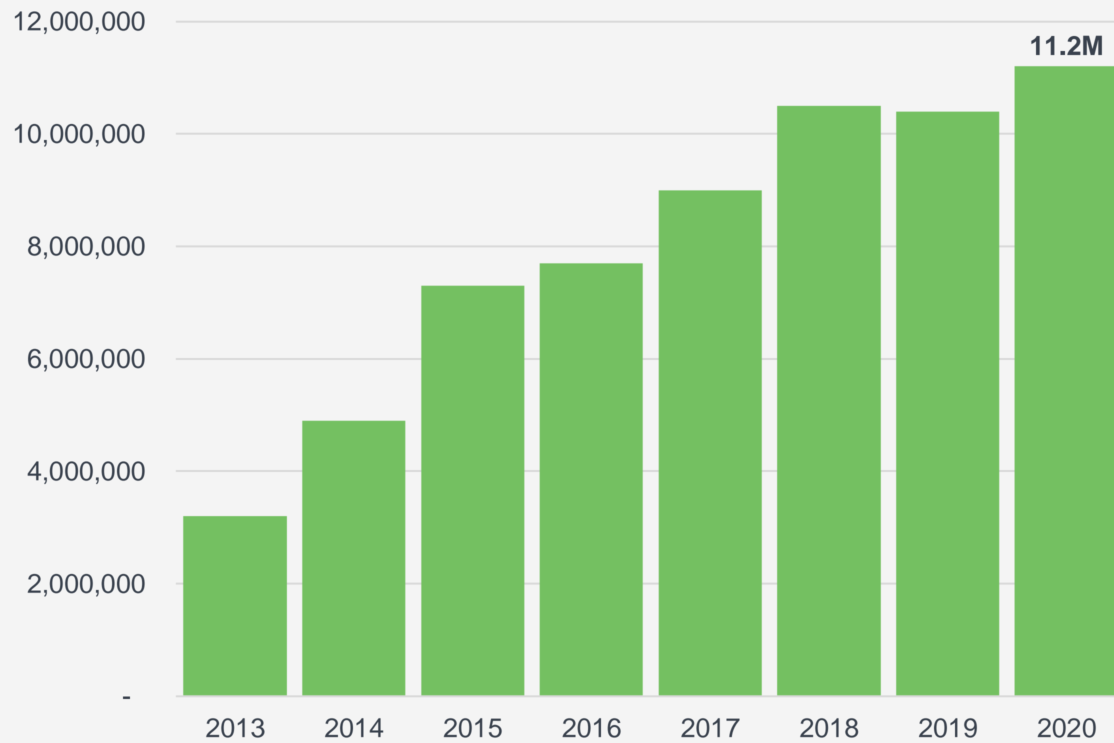
Source: Map data downloaded January 11, 2018 from CMS, "Where Innovation is Happening," and "Performance Year 2018 Medicare Shared Savings Program Accountable Care Organizations – Map."

MSSP participation by track option

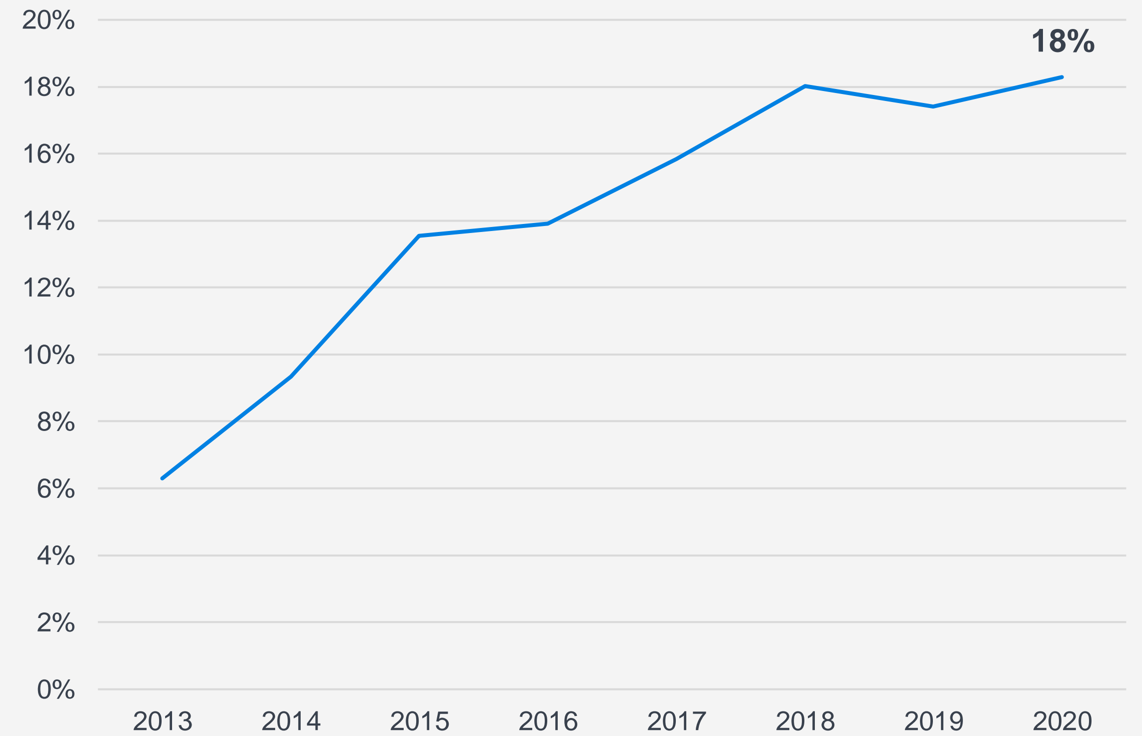


MSSP participation

MSSP ACO attributed lives



MSSP ACO attributed lives as % of Medicare population



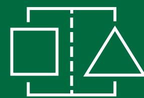
How are ACO payment models structured?

Medicare FFS beneficiaries

Claims-based attribution

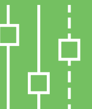
Historical expenditures

Regional comparison



Quality

Track options

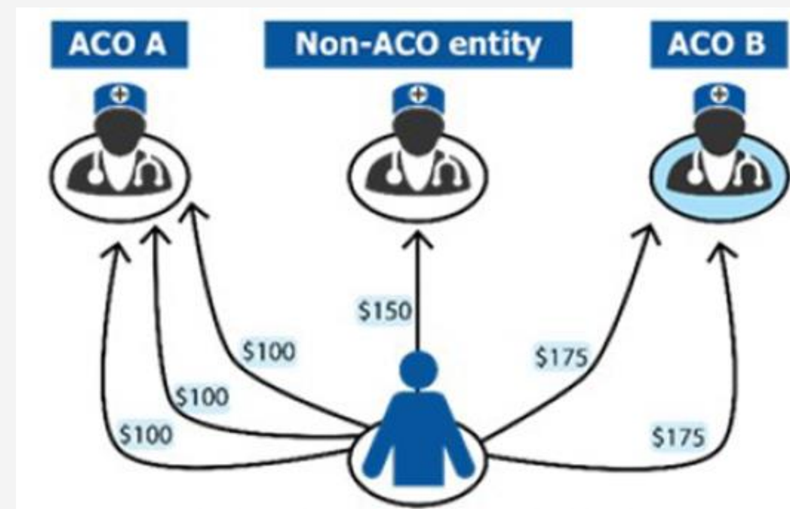


Beneficiary attribution

Claims-based attribution

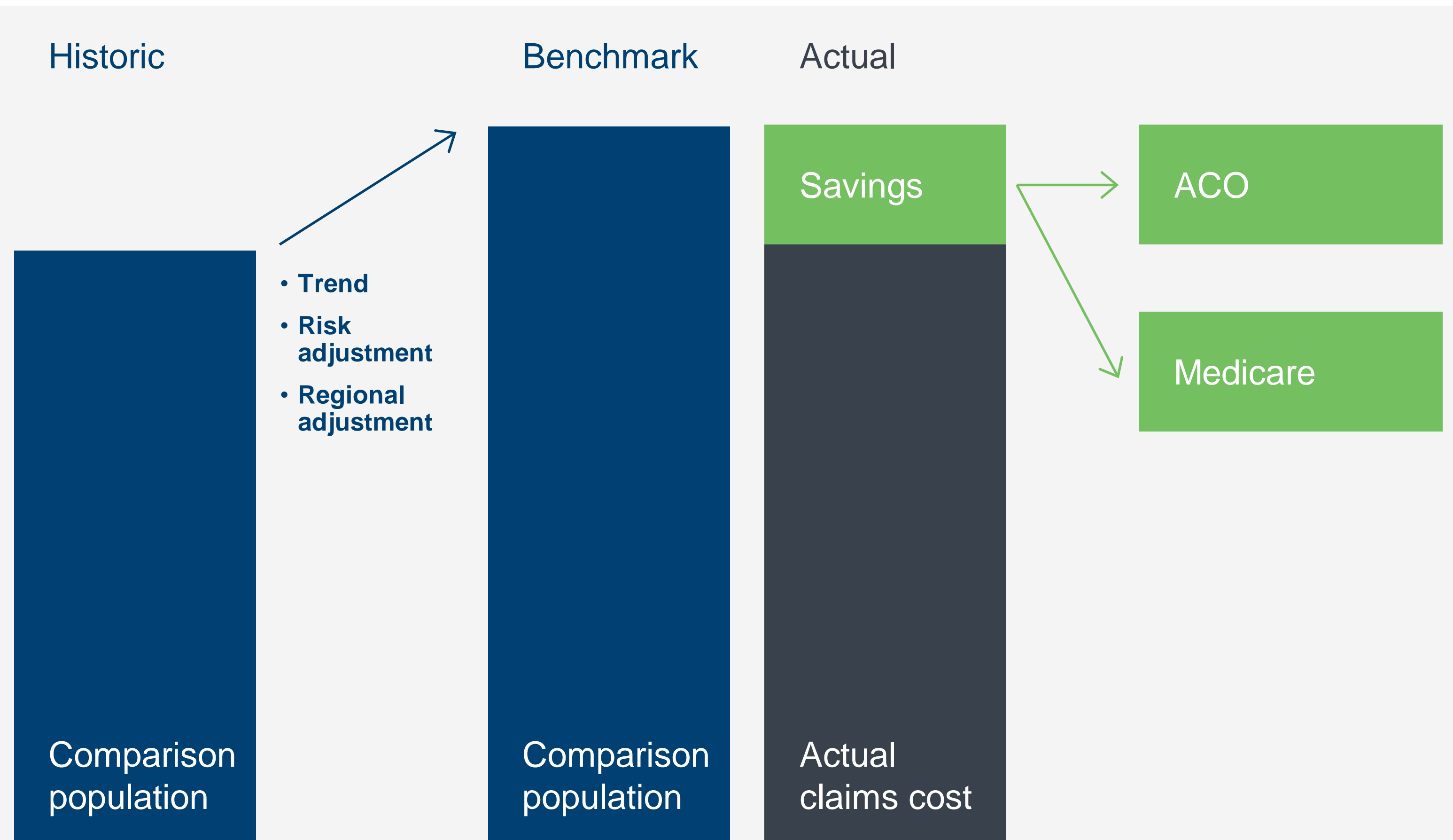
Plurality of care

Prospective or retrospective



Benchmark build-up

- Conceptually, ACO's are measured against a benchmark.
- If actual claim costs come in below the benchmark, then CMS shares a portion of the savings with the ACO.
- In certain models / tracks, if actual claim costs are above the benchmark, then the ACO may need to partially repay CMS for the losses.



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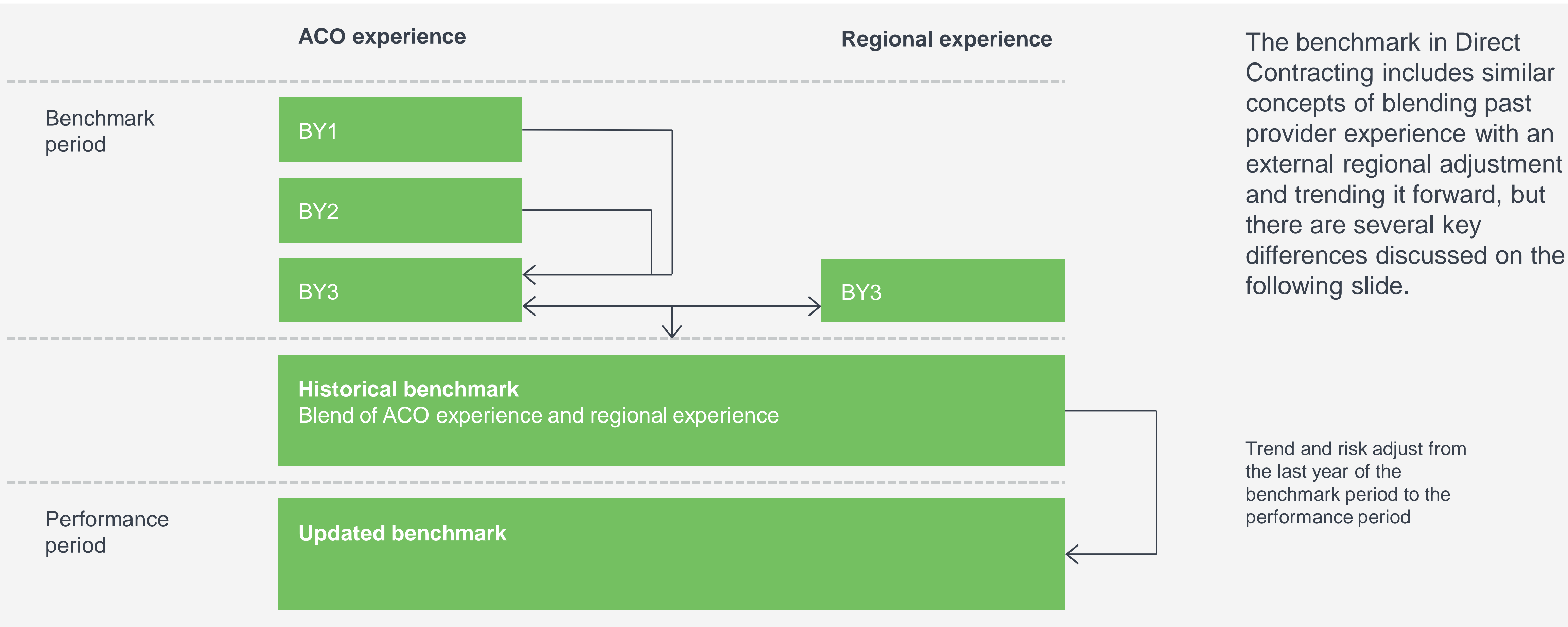
What is the basis for the benchmark?

Example using MSSP build-up



The benchmark in Direct Contracting includes similar concepts of blending past provider experience with an external regional adjustment and trending it forward, but there are several key differences discussed on the following slide.

Trend and risk adjust from the last year of the benchmark period to the performance period

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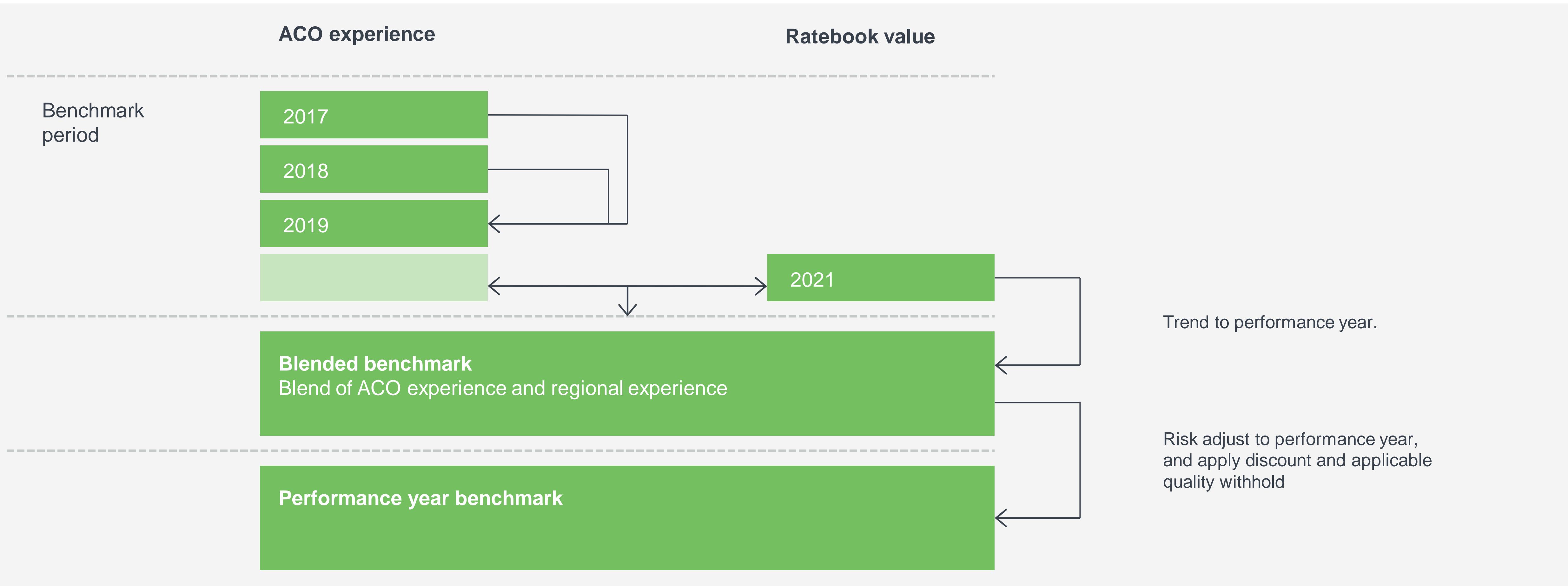
What is the basis for the benchmark?

Example using Direct Contracting



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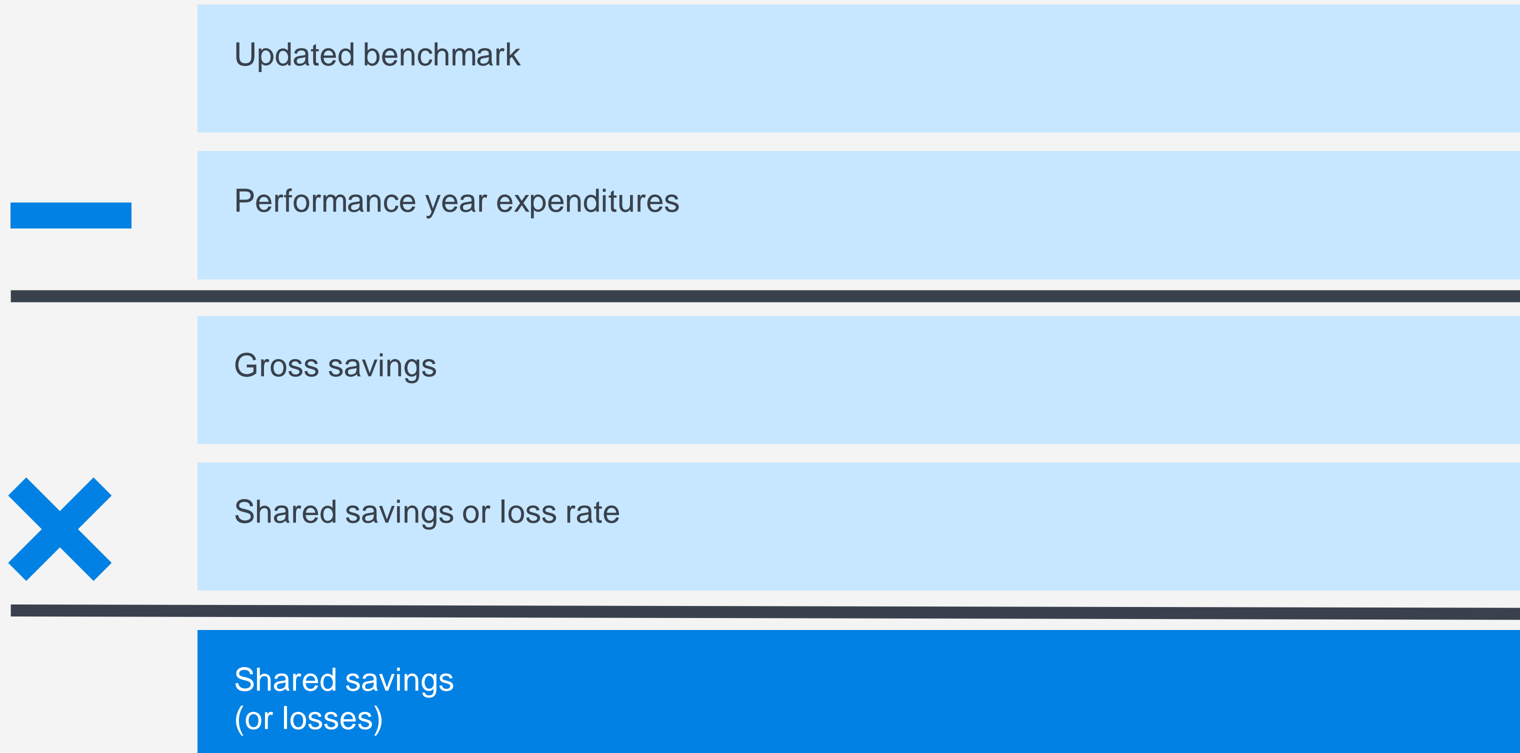
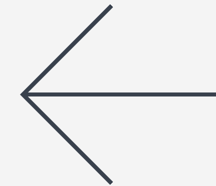
How are savings shared with the ACO?



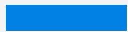


Gross savings or losses may need to exceed a hurdle called a “Minimum Savings Rate” (MSR) or “Minimum Loss Rate” (MLR) to share I savings or losses. MSRs are required in one-sided models, and are based on an ACO’s size with a minimum value of 2%. ACO’s in two-sided risk may elect to have MSR / MLRs between 0% and 2%

How are savings shared with the ACO?

MSSP

Updated benchmark

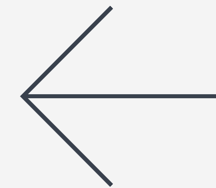


Performance year expenditures

Gross savings

Shared savings or loss rate

Shared savings
(or losses)



The savings rate typically ranges between 50% - 75%, while the loss rate typically ranges between 30% - 50%.

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How are savings shared with the ACO?

MSSP

Updated benchmark

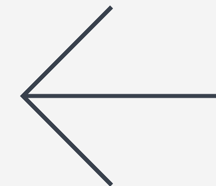
−

Performance year expenditures

Gross savings

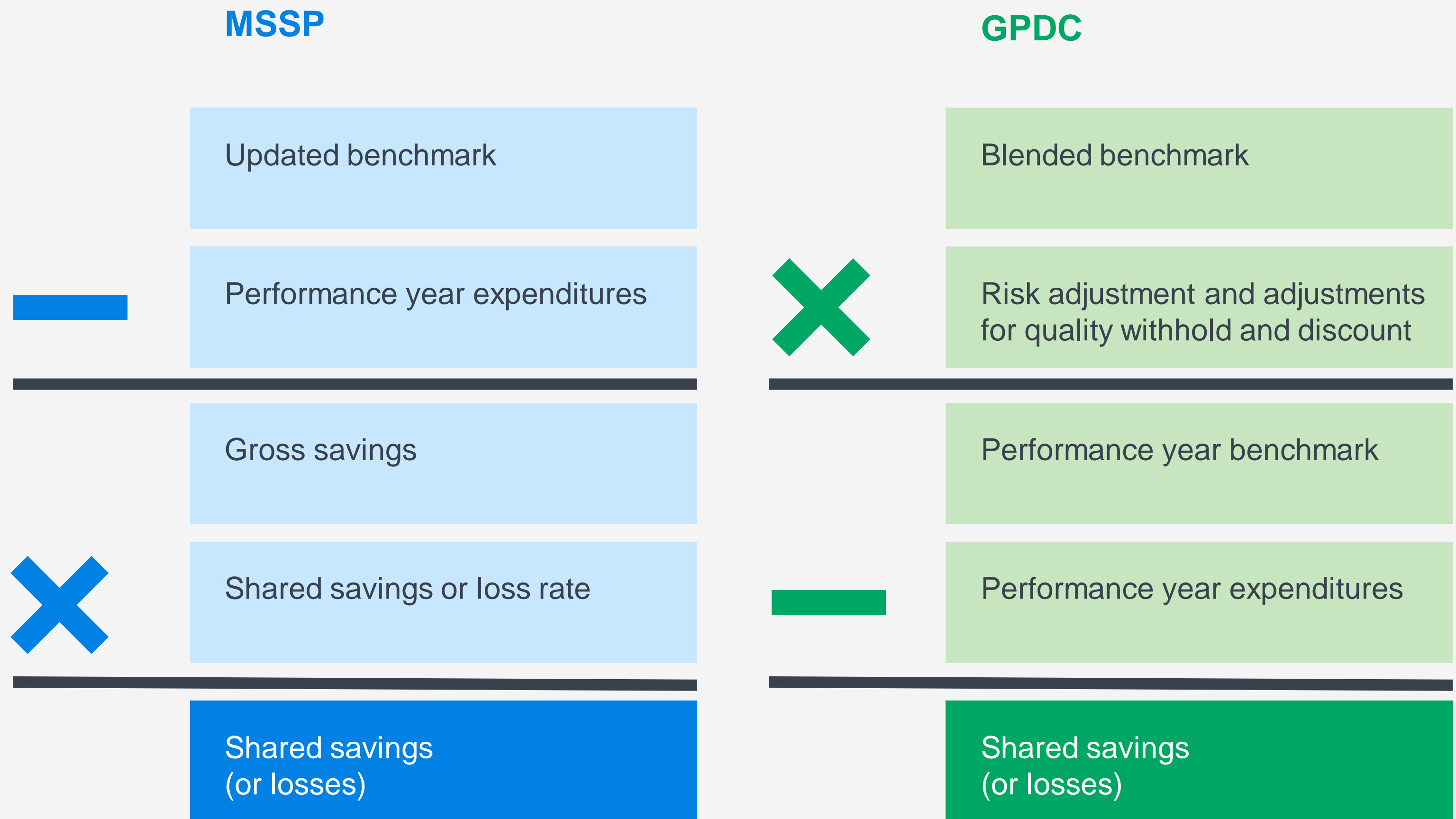
Shared savings or loss rate

Shared savings
(or losses)



There are aggregate caps on shared savings or losses, which differ by risk track.

How are savings shared with the ACO?



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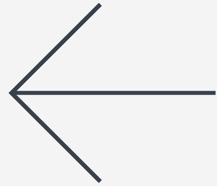
How are savings shared with the ACO?

MSSP

	Updated benchmark
−	Performance year expenditures
	Gross savings
×	Shared savings or loss rate
	Shared savings (or losses)

GPDC

	Blended benchmark
×	Risk adjustment and adjustments for quality withhold and discount
	Performance year benchmark
−	Performance year expenditures
	Shared savings (or losses)



The blended benchmark is subject to caps on how much it can differ from the ratebook.

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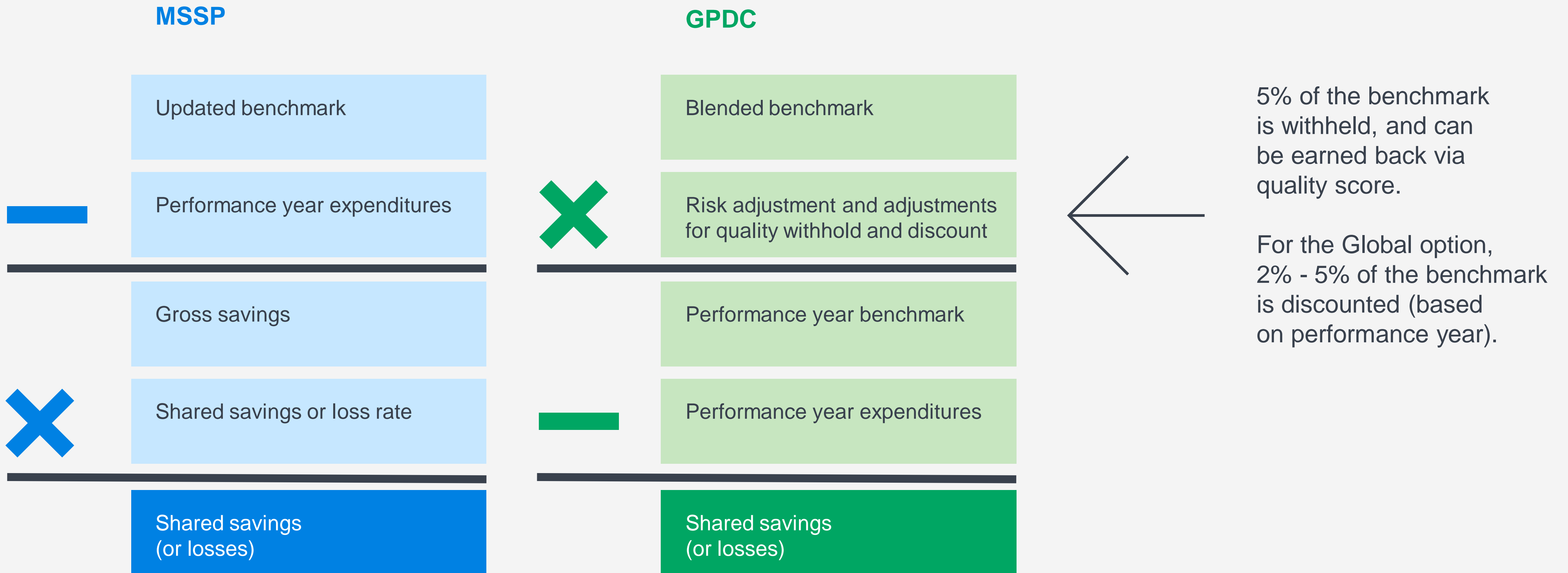
How are savings shared with the ACO?



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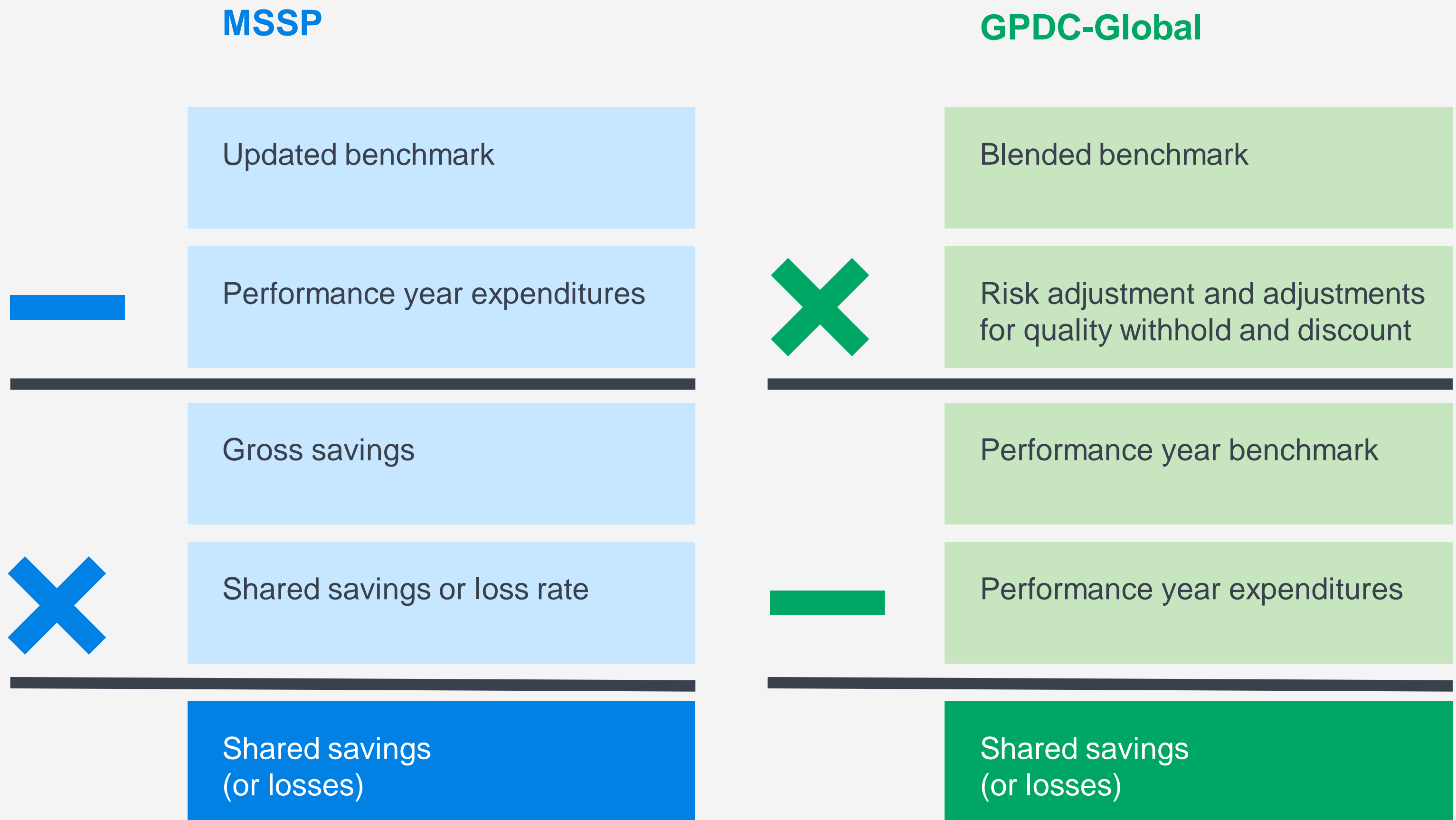
How are savings shared with the ACO?



You will notice that we have skipped the step where we multiply by shared savings or loss rate. In the Global option, 100% of savings are losses are shared within a certain margin.

MSSP compared to Direct Contracting

Feature	MSSP	Direct Contracting
Baseline period	3 years prior to start of agreement period.	2017-2019
Shared savings / losses	Asymmetrical sharing rates, with greater opportunity for savings than losses.	Highest opportunity for shared savings with up to 100% sharing. Symmetrical sharing rates.
Regional impact	▪ 35% to 50% if ACO is more efficient than the region. ▪ 15% to 50% if the ACO is less efficient.	Regional benchmark receives 35% weight in PY2022, growing to 50% by PY2026.
Discount rate	n/a	For Global track, 2% increasing to 5%.
Risk exposure	Percent of benchmark and percent of revenue limits.	▪ Risk corridors that vary by track option. ▪ Optional stop loss.
Preferred providers and advanced payments	n/a	Ability to contract with downstream providers with alternative reimbursement models and capitation options.
Can health plans participate?	No	Yes

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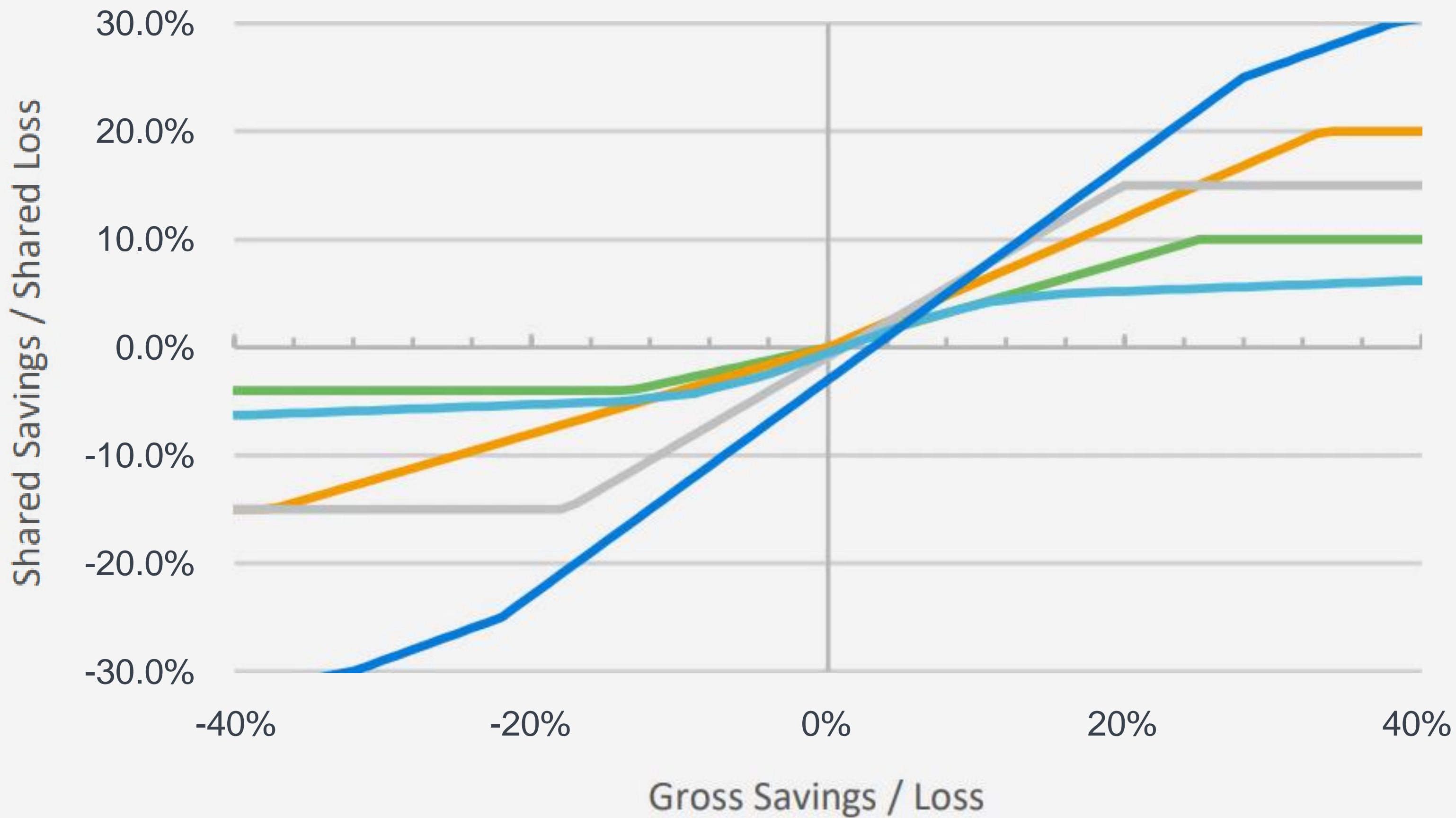
How are savings shared with the ACO?



Assumes 80% quality score for both DC tracks, and 2% discount for DC-Global.

- MSSP BASIC Level E
- NGACO
- DC-Global
- MSSP Enhanced
- DC-Professional

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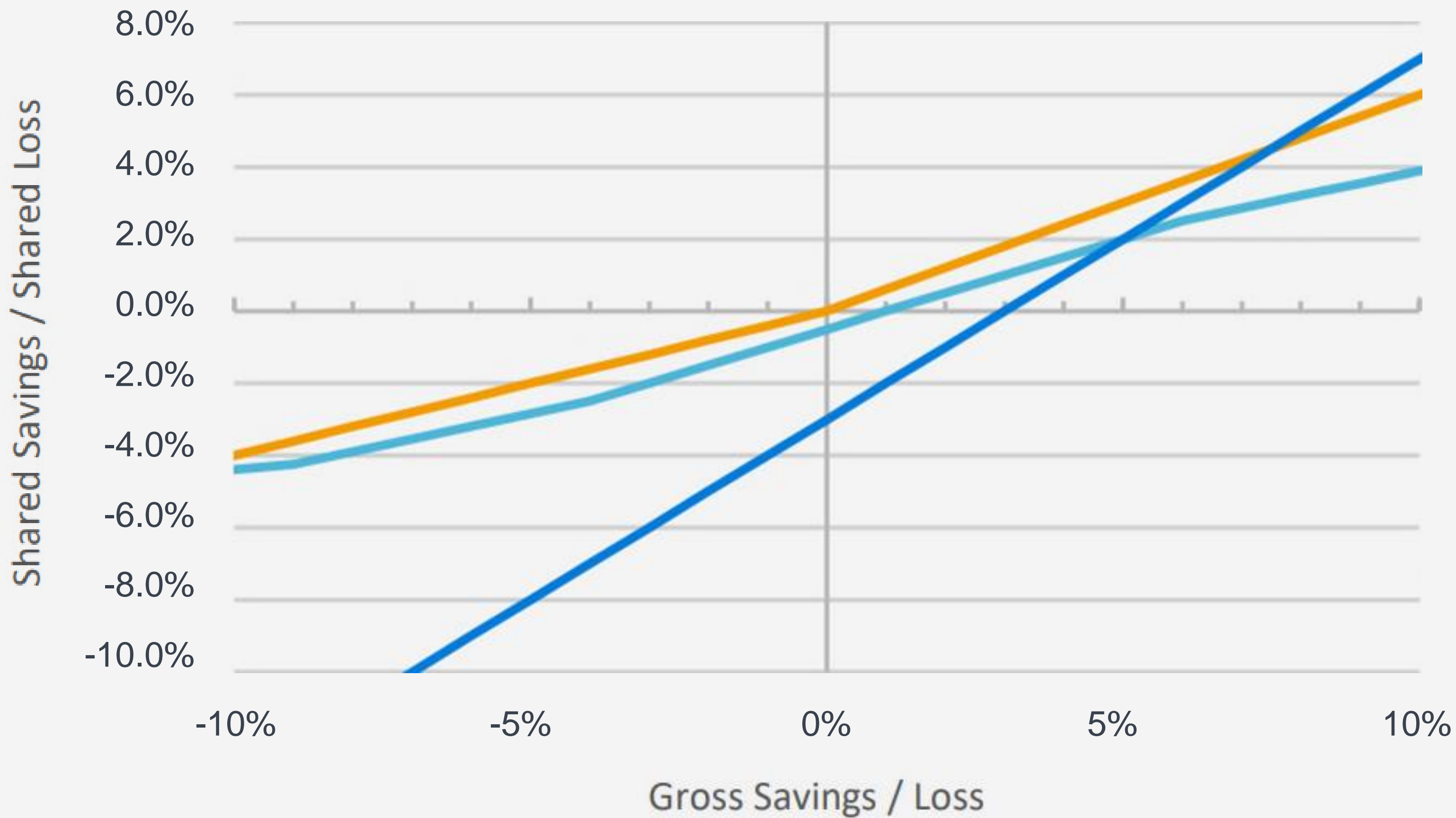
How are savings shared with the ACO?



Assumes 80% quality score for both DC tracks, and 2% discount for DC-Global.

- MSSP ENHANCED
- DC-Global
- DC-Professional

Example: Settlement in MSSP Enhanced vs. Direct Contracting-Global

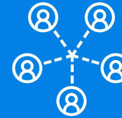
	MSSP Enhanced	Direct Contracting-Global
ACO 1 Benchmark: $10,000 PBPY Performance: $9,800 PBPY	Gross savings: $200 PBPY Shared Savings: 75% x $200 = $150 PBPY	Discounted Benchmark: $10,000 x (1 – 3%) x (1 – 0.5%) = $9,650 Gross savings: -$150 PBPY **Shared Loss: -$150 PBPY**
ACO 1 Benchmark: $10,000 PBPY Performance: $9,800 PBPY	Gross savings: $1,500 PBPY Shared Savings: 75% x $1,500 = $1,125 PBPY	Discounted Benchmark: $10,000 x (1 – 3%) x (1 – 0.5%) = $9,650 Gross savings: $1,150 PBPY Shared Savings: $1,150 PBPY
	Assume quality hurdle rate is met, 0% MSR, and savings are shared at 75%.	Assume quality score of 90% (i.e. 0.5% final quality discount to benchmark), and 3% discount.

A match made in heaven

Why it makes sense for an MA Plan to become a DCE

Expand covered lives / increase market share

Increased provider / network engagement

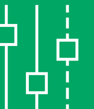


Increase operating profits across all LOBs by spreading costs across a larger population

Improve competitiveness of other products (Med Supp, etc.) via savings generated from care management or contracting

In 2019, there were 97 ACOs in two-sided risk in MSSP.

76 generated earned savings payment of an average of 3.3% of benchmark.



MA vs. DC

	Medicare Advantage	Direct Contracting
Enrolment	Selected and purchased by MA Beneficiaries	Medicare FFS lives Attributed via Primary Care
Revenue	Combination of CMS Ratebook and Bid	Blend of historical and regional expenditures
Benefits	Medicare FFS & Supplemental Benefits (Maybe Part D)	Medicare FFS Only
Network	Ability to limit network	No ability to limit network
Provider contracting	Yes	Yes
Administrative costs	Higher	Lower (Typically)
Risk score coding opportunity	Uncapped	Capped (at 3% growth or reduction versus reference year)

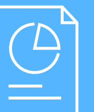
Why MA plans are positioned to be successful DCEs

Leverage existing provider relationships/contracting

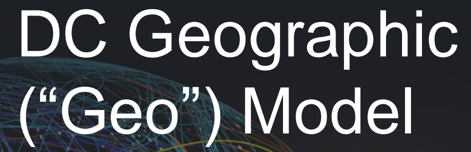
Leverage existing health plan functions to manage costs

- Care management programs
- Risk score coding initiatives

Leverage existing CMS reporting and administrative functions



The Future of Direct Contracting

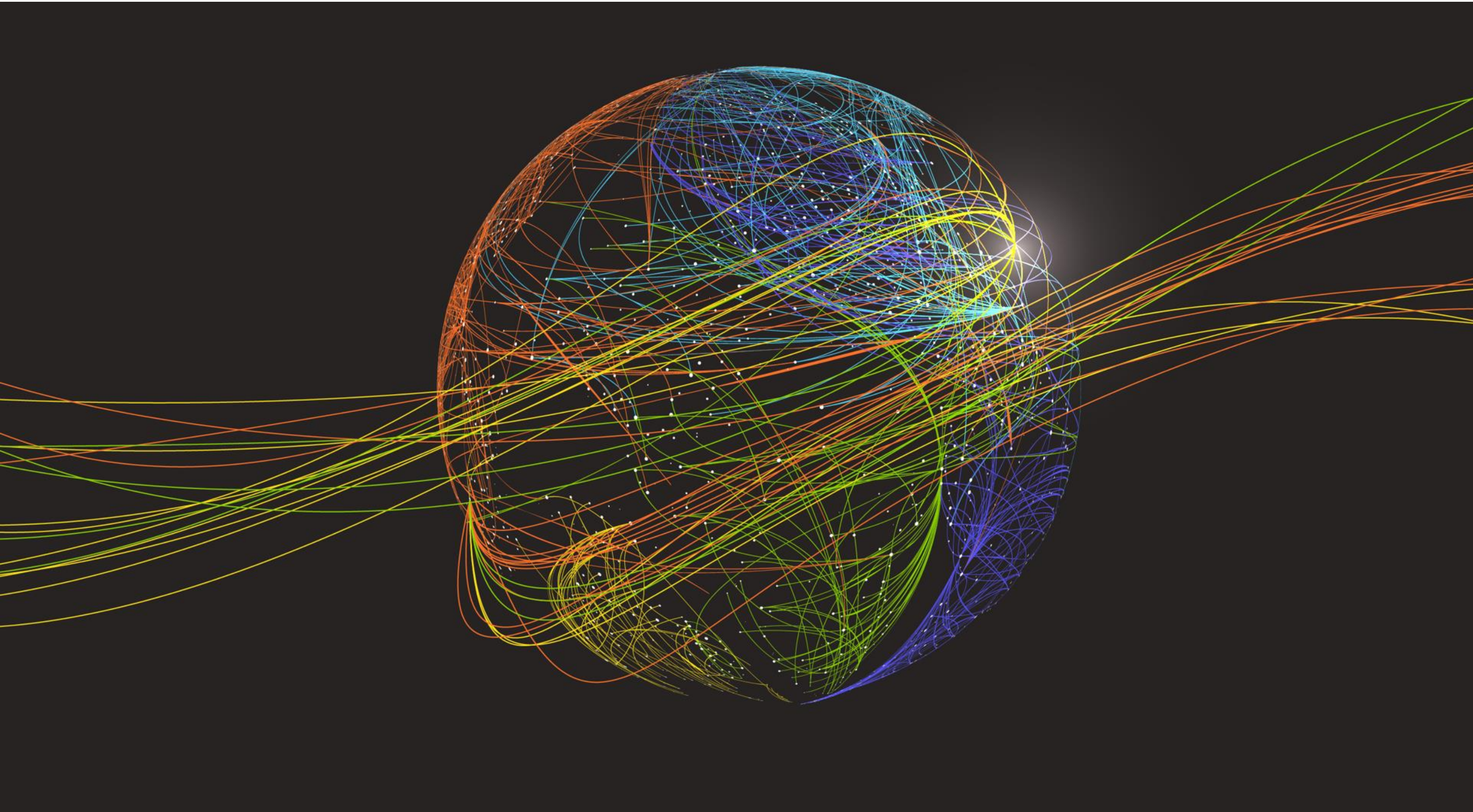


Shift risk away from CMS

QP status / APM bonus

- Providers are considered qualifying participants (QPs) based on the percentage of patients/dollars they see through an Advanced Alternative Payment Model (APM)
- Advanced APMs include models such as MSSP and DC
- If a provider is a QP, they will receive a 5% bonus on all Part B payments and be exempt from the MIPS program
- 5% bonus is scheduled to sunset (last payment in 2024) and starting in 2026, QPs will receive a 0.75% increase in PFS payments

DC Geographic ("Geo") Model



- Originally announced in late CY2020
- Participants split up all Medicare FFS beneficiaries in select regions
- Revenue based on historical spend of region including a discount
- Program is currently on hold with no timetable for reintroduction

Questions?

Caveats, limitations, and qualifications

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