Determining Your Medicare Value-Based Strategy for 2025 and Beyond

Joe Satorius

Senior Vice President, Operations & Enterprise Strategic Initiatives

Eric Weaver

Vice President, Strategic Marketing

Determining Your Medicare Value-Based Strategy for 2025 and Beyond

The Opportunity is Now

Now is the time for healthcare leaders to fully commit to a value-based care transformation strategy. Within the next couple of months, there is an opportunity to join a value-based Medicare program offering that unlocks the potential for long-term strategic positioning and financial security. Economic models and structures that align with the reorganization of care delivery to two-sided risk contracts are a strategic lever for amplifying upside opportunities in both clinical and financial transformation. Waiting on the sideline altogether, or just delaying the full optimization of your risk-based revenue portfolio in the Medicare FFS program, can have deleterious effects on long-term solvency and prolong critical transformation in care delivery. By capitalizing on this open window to join the **Medicare Shared Savings Program (MSSP) or the ACO Realizing Equity Access, and Community Health (REACH) Model**, your health system or physician practice will be positioned to not only mend the sick but invest in the wellbeing of communities, forging a foundation for financial stability through proactive and preventive care. Participation in MSSP or REACH will also serve as a testing ground for readiness in value-based practices, aligning with CMS' ambitious goal of having 100% of Traditional Medicare beneficiaries in accountable care relationships by 2030.

The Bigger Picture for Value

The sense of urgency for value-based payment adoption could not be more imperative in the short-term, as it represents not only a pivotal shift towards a more sustainable and patient-centric delivery system but also a decisive step in aligning incentives for providers, payers, and patients, fostering improved outcomes, cost-effectiveness, and overall healthcare excellence. Accepting calculated financial risk in the Medicare FFS program with a partnering influencer that can provide population health enablement expertise and cutting-edge technology will ensure strategic capitalization of upside potential and mitigation of downside risk exposure.

The deteriorating financial performance of hospitals and health systems has prompted ratings agencies, the American Hospital Association, and other industry insiders to warn that current conditions are untenable without value-based payment adoption. The same can be said of independent primary care practices that face mounting pressures to shift towards value-based payment structures that provide financial viability in the demonstration of high-quality care, care coordination, and enhanced population health management.

The unsustainable trajectory of the fee-for-service dominated American healthcare industry is a canary in the coal mine signaling a looming financial meltdown, but the risk of this daunting scenario can be ameliorated through the adoption of value-based payment models in the Medicare program. These structures provide a pathway to thrive in a changing healthcare landscape, encouraging a focus on preventive services, chronic disease management, and overall patient wellness.

The 2025 Strategic Planning Process

Healthcare leaders will need to decide which, if any, Medicare programs to participate in as they prepare to meet with their boards in May or June. Fortunately, if leaders begin the planning process now, they can make the most informed decision about participation in the MSSP or ACO REACH value-based programs for the upcoming 2025 Performance Year. The key to selecting the right program for your provider network will require:

1. Awareness of payment model design attributes specific to various MSSP tracks and ACO REACH, including upside opportunity potential balanced by downside risk exposure, benchmarking methodologies, benefit enhancements, capitation payment methods, and beyond.

2. A comprehensive understanding of the network's risk-adjusted performance conducted at the NPI level to better inform the overall appetite and readiness for moving towards fully delegated risk models.

If leaders select programs with downside risk that their network isn't fully equipped to handle, they risk having to foot a large bill to CMS during reconciliation the following year. Conversely, if they over-cautiously select a program that offers too little upside opportunity for a system already on the value-based care transformation curve, they risk forfeiting significant earned savings to CMS and risk not having enough savings distribution for their network. The latter scenario of an overly conservative approach or "analysis paralysis" leading to undue financial risk aversion not only limits upside rewards; it poses an unintended consequence of losing aligned providers and beneficiaries to other networks, physician aggregators, and vertically integrated payers that provide access to total cost of care models with the population health enablement capabilities to succeed. To arm leaders with the information they need to make these critical decisions, Lumeris has summarized the differences between the MSSP and ACO REACH models, timelines for participation, and analyzed how key programmatic updates will likely impact providers participating in value-based care.

While many networks are looking to test out their value-based competencies and need a risk corridor buffer, market disruptors and CINs with the resources and experience to successfully manage total cost of care are looking to capitalize on the significant investments they've made into population health to increase their access and capture of first dollar risk. Primary care centric organizations are looking to partner with their PCPs in total cost of care models, while large multispecialty groups and academic medical centers are seeking to optimize incentives for their specialists. If health systems and CINs participating in value-based care choose to move their providers through the risk continuum uniformly, there will certainly be missed opportunities and greater potential for losses. With NPI level participation available in newer CMS programs such as ACO REACH, options can and likely should be combined depending on organizational priorities and existing network makeup and infrastructure rather than the one-size-fits-all approach to contracting that is most common today.

Figure 1 provides a comparison between the MSSP and ACO REACH programs in alignment with key program dynamics to consider for your organization.

FIGURE 1:

Program Comparison and Key Considerations

	MSSP	ACO REACH	KEY CONSIDERATIONS	
First Dollar Earning Opportunity	◐	●	**M**	40 - 75% x Quality Score once minimum shared savings rate (MSR) is met or exceeded. Depending on track an ACO could choose first dollar (no MSR)
			R	50% / 100% of first dollar savings after 3.5% CMS Discount, depending on Professional / Global track, no MSR
No Cap on Earnings / Losses	○	◐	**M**	Shared savings cap (Basic: 10% of updated benchmark, Enhanced: 20% of updated benchmark)/shared losses cap (Basic: N/A or 1-4% of updated benchmark, Enhanced: 15% of updated benchmark)
			R	Variable risk corridors depending on performance and Global/Professional track with option to purchase stop-loss from CMS
Advanced Alternative Payment Model Eligible	◐	●	**M**	Qualifies as AAPM in Track E or Enhanced only
			R	Qualifies as AAPM
MA-like Benefit Enhancements & Engagement Incentives	◐	●	**M**	SNF, Telehealth, Beneficiary Incentive Program
			R	NP, SNF, Home Health, Telehealth, Hospice, Post-Discharge, Cost-Sharing Support, CDM Reward Program, Vouchers for OTC Meds/Wellness Programs/BP Monitors
Downstream Payment Flexibility	○	●	**R**	Flexible primary and total care capitation
TIN / NPI-Level Segmentation	○	●	**R**	Participant/preferred providers contracted at TIN / NPI level and can be added or removed annually

KEY: **M:** MSSP | **R:** REACH | ● Yes | ◐ Maybe / Sometimes True | ○ No

Program Updates to Consider in Payment Model Selection for PY 2025

The Medicare Shared Savings Program (MSSP)

What's New: The Final 2024 MPFS was released on November 2nd, 2023. According to a recent press release from NAACOs, "this rule finalizes several policies that support clinicians in accountable care organizations (ACOs), including improvements in quality reporting, more fair benchmarking policies, a smooth transition to a new risk adjustment model, keeping advanced payments for new ACOs that transition to risk, helping ACOs that serve high-cost beneficiaries and others."[1]

What to Know about MSSP Participation:

- CMS is slowing the glidepath to the highest level of risk by providing additional time in upside-only for new ACOs and retaining upside-only for existing ACOs in upside tracks today.
- The Final 2024 MPFS Rule eliminated negative regional adjustment, preventing an ACO's benchmark from being lower than it would have been absent a regional adjustment.
- Accounting for an ACO's prior savings in rebased benchmarks to help mitigate the lowering of an ACO's benchmark over time (ratcheting effect).
- The MSSP allows for higher risk adjustment during a contract term by accounting for demographic changes before applying the 3% cap on risk score growth.
- The new HCC risk adjustment model version (V28) is being implemented in 2024 and will be phased in for three years. It applies to all ACOs, regardless of starting a new agreement period or not (1/3 of risk scores in 2024, 2/3 of risk scores in 2025, and 100% of risk scores in 2026).
- CMS has changed the quality scoring approach to allow more ACOs to achieve a portion of savings. The Final 2024 MPFS Rule updates the quality performance standard and ensures that CQM reporting continues to apply only to Medicare patients (as opposed to traditional MIPS quality reporting which applies to all Medicare and non-Medicare patients).
- The MSSP applies a health equity adjustment increase to quality scores for ACOs serving high proportions of underserved beneficiaries.
- CMS may provide advanced shared savings payments to smaller ACOs that serve underserved populations.
- The fee-for-service payment for physicians was reduced in the Final 2024 MPFS Rule, with a conversion factor decrease of 3.4%, whereby further jeopardizing the financial sustainability for healthcare organizations not diversifying their Medicare revenue stream with Shared Savings from ACO participation.

KEY INSIGHT

For organizations newer to value-based care that are getting their feet wet in managing total cost, MSSP remains a strong option as it has guardrails and policies in place to protect participating organizations and provides ample opportunity to achieve shared savings. However, organizations should regularly evaluate the performance of their network at the NPI level to determine whether providers are demonstrating the readiness to graduate to higher levels of risk with greater incentives. It is noteworthy that ACOs in two-sided risk models are more likely to achieve savings and have a higher average savings rate than their peers in upside only.[2]

[1] https://www.naacos.com/press-release--naacos-statement-on-final-2024-medicare-physician-fee-schedule
[2] https://www.lumeris.com/risk-for-reward-two-sided-risk-is-crucial-to-win-in-value/

ACO Realizing Equity Access and Community Health (ACO REACH)

The ACO REACH model incentivizes community-based physicians and health systems to provide comprehensive care coordination, accountable primary care and health and wellness services to Medicare beneficiaries with additional focus on improving heath equity by bringing the benefits of accountable care to Medicare beneficiaries in underserved communities. It uses many of the same operating levers as Medicare Advantage such as beneficiary engagement incentives, benefit enhancements, and pass through of benefits to preferred providers. With partial or full capitation (like delegated capitation in MA), REACH ACOs will assume financial risk for the population under management. Claims payment is reduced by CMS and replaced with capitation payment from ACO.

Participants in the ACO REACH Model may elect from one of two risk options, Global risk (100% risk for shared savings/losses), and Professional (50% risk for shared savings/losses). For PY2024, 103 ACOs elected Global risk and 19 chose Professional risk.

What's New: ACO REACH (previously the Global & Professional Direct Contracting Model) is Medicare's fastest growing program with a 33% increase in participating ACOs from 2022 to 2023. The model is currently scheduled to continue until the end of calendar year 2026 and CMS is exploring a full risk track in MSSP as ACO REACH sunsets at the end of PY 2026.

For PY 2024, there are 122 participating ACOs, providing care to ~2.6 million aligned beneficiaries (as compared to 53 participating ACOs providing care to ~350k aligned beneficiaries in PY 2021 in the first year of GPDC). The increase in aligned beneficiaries represents a 7X growth from 2021-2024.

Participating ACOs in the REACH program generated $371.5 million in savings for the Medicare program in PY 2022.[3] With a focus on quality care, Lumeris' affiliate entities, serving 79,000 seniors under the care of 1,600 participant providers, achieved 100% quality scores while delivering a 4.3% gross savings rate, including $20.1M in savings to the Medicare Trust Fund and federal government for the 2022 performance year.[4]

KEY INSIGHT

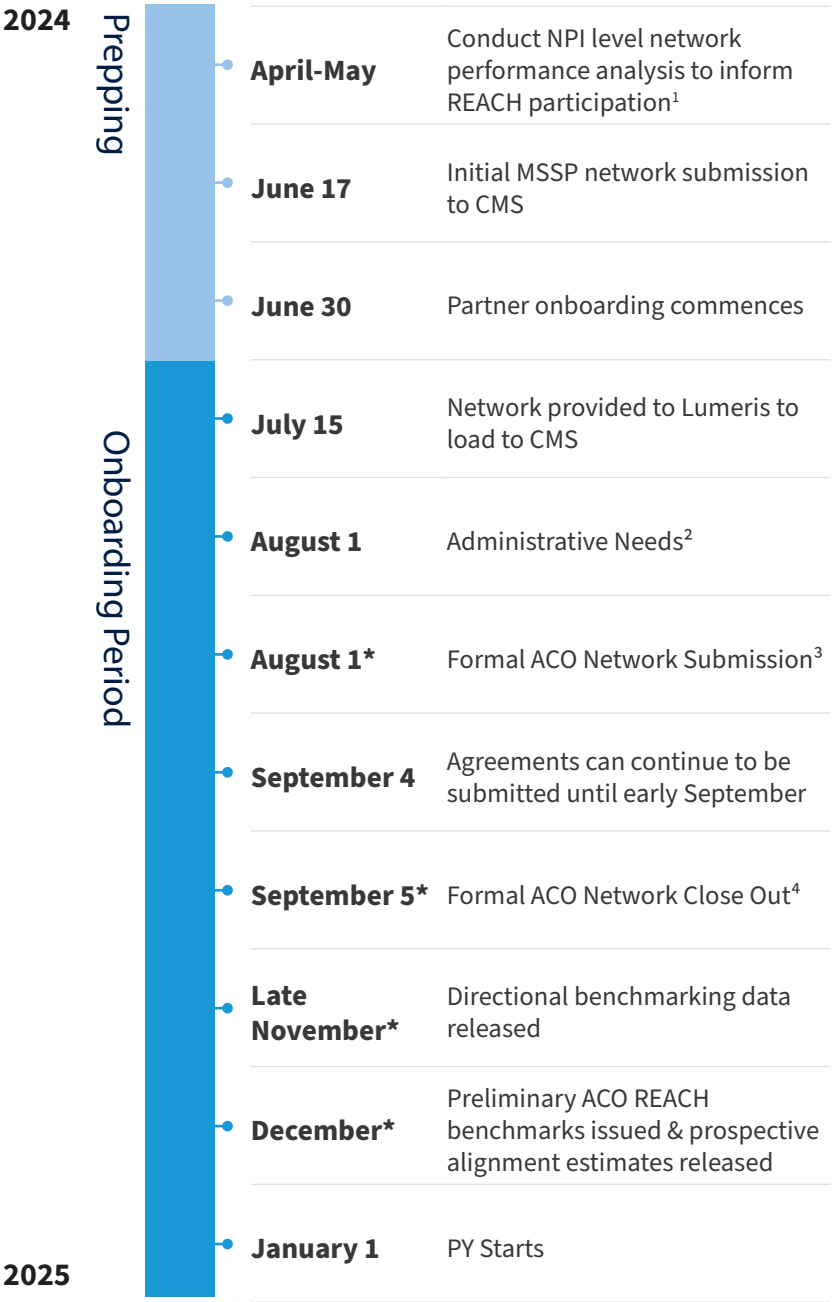
ACO REACH is a strong option for provider organizations that have experience in value-base care and have the capabilities to meet the advanced requirements of the ACO REACH model. With the ability to include providers at the NPI level, ACO REACH can expose high performing providers within networks to the highest level of savings while mitigating downside exposure. Of the available Medicare Programs, ACO REACH is most similar to Medicare Advantage in its ability to generate significant savings and meaningful incentives for providers while incorporating options for benefit enhancements typically only found in MA that more closely align consumers to providers organizations.

[3] https://www.cms.gov/files/document/aco-reach-py2024-participants.pdf
[4] https://www.prnewswire.com/news-releases/lumeris-achieves-100-quality-scores-and-delivers-20-1m-savings-to-medicare-trust-fund-and-federal-government-through-aco-reach-302000596.html

Projected Medicare Program Timeline for 2025 Participation

Still awaiting the release of official dates for PY25 at the time of publishing

Medicare ACOs (REACH & MSSP)



PROGRAMMATIC NEEDS

1
- NPI Market Analysis
- Readiness Assessment

2
- Provider Participation Agreements in place executed
- Partner confirms withdrawal from competing programs

3
- The final participant and preferred provider list - no adds after this date

4
- Last chance to drop participant and/or preferred providers

*CMS identified that date windows are subject to change.

MSSP 2024 onboarding document: https://www.cms.gov/files/document/key-application-actions-and-deadlines.pdf

BPCI-A 2024 onboarding document: https://innovation.cms.gov/innovation-models/bpci-advanced/applicant-resources

THE KEY TAKEAWAY

The time to take action in formulating your value-based care strategy for 2025 and beyond is now.

Healthcare leaders must carefully evaluate the respective benefits and risks associated with participating or not-participating in each of the value-based programs highlighted as the industry continues to evolve towards more mature levels of delegated risk sharing. Within large networks of providers, it is unlikely that a one-sized-fits-all-approach to participation in these products will be successful in maximizing revenue opportunity and premium capture while minimizing downside exposure.

What's next for your network in 2025?

To discuss how these programs will impact your network and discover Lumeris' approach to managing risk, contact: info@lumeris.com

About the Authors

Joe Satorius

Joe Satorius serves as Senior Vice President, Operations & Enterprise Strategic Initiatives. In this capacity, he oversees comprehensive performance and operational functions related to population health initiatives, provider partnerships, and Direct Contracting (ACO REACH) programs. Mr. Satorius brings deep expertise in alternative payment models which reward health care providers for delivering high-quality and cost-efficient care and is a sought after speaker and authority on CMMI programs.

Connect on LinkedIn

Eric Weaver

Dr. Eric S. Weaver serves as Vice President, Strategic Marketing. Dr. Weaver is nationally recognized for his work in primary care transformation and value-based care. Prior to his current role at Lumeris, he served as the Executive Director of the Institute for Advancing Health Value, a nonprofit organization established by former HHS Secretary Mike Leavitt and former CMS Administrator Dr. Mark McClellan to accelerate the value-based care readiness of healthcare organizations. Dr. Weaver has an extensive executive leadership track record with physician-led ACOs and risk-bearing entities. He is also known as widely as an industry thought leader in value-based care transformation.

Connect on LinkedIn

Contributing Authors

Rick Goddard
VP, Head of Commercialization & Strategy

Nico Neugebauer
Director, Strategic Partnerships

Sindhu Dokuru
Manager, Partner Strategy

About Lumeris

Lumeris is the market leading value-based care enablement company bringing more than 10 years of experience as a pioneering force helping health systems and physician practices succeed in value-based care. A joint-operating partner in both value and risk, Lumeris delivers market-leading technology, insurance capabilities and on-the-ground expertise. Our partners are able to achieve superior quality metrics, patient experience, physician satisfaction and improvements in the total cost of care for Medicare Advantage, Original Medicare, Medicaid and Commercial populations. With more than $13 billion of medical spend under management across more than 12 markets, we are creating a system of care that every doctor wants for their family.

Discover the perks of partnership:

lumeris.com