**MSSP vs ACO REACH: Five Considerations for Legal Counsel**

As the value-based reimbursement landscape in healthcare continues to evolve, providers have an increasing array of models and options available to them, across various classes of payors. Value-based models available to providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) have been at the forefront of the innovation for more than a decade in the Medicare space through the Medicare Shared Savings Program (MSSP) and other value-based models tested by the Centers for Medicare and Medicaid Innovation (CMMI).

While MSSP has been a dominant driver of participation in Medicare value-based care for a number of years,[1] many physician practices and health systems are exploring other alternatives, and for providers ready to take on an enhanced level of payment risk, the recently implemented ACO Realizing Equity, Access, and Community Health (REACH) Model option has some attractive qualities. Introduced in 2022 as a replacement to the Global and Professional Direct Contracting Model, for 2023, ACO REACH boasts 132 ACOs aligning with 131,772 health care providers and organizations providing care to an estimated 2.1 million beneficiaries.[2] Similar to other value-based models, the aim of ACO REACH is to encourage providers to coordinate care to improve the quality of services offered to the Medicare population, including underserved communities.

At the forefront of a decision whether to join ACO REACH or another risk-based capitated model are complex financial and operational considerations to assess whether a particular practice or health system is operationally ready for risk, whether the anticipated attributed patient population is well-suited for a capitated model, and whether a potential ACO REACH partner aligns with the provider's culture and population health goals.

However, alongside those considerations are a number of additional factors that legal counsel advising such providers should be aware of when considering a potential shift from MSSP to ACO REACH. This alert briefly discusses five of these additional questions providers should evaluate when considering a switch:

1. Does our organization have providers looking to join a variety of shared savings models?
    - Unlike MSSP, ACO REACH is structured to allow different providers and specialties within an organization to participate in different models.
2. Can we take advantage of additional flexibilities to incentivize patient participation?
    - The ACO REACH Model offers additional fraud and abuse flexibilities that can allow for a greater amount of beneficiary engagement and support.
3. Would we benefit from additional Medicare program flexibilities?

[1] MSSP currently includes 456 ACOs, covering case for 10.9 million assigned beneficiaries. 2023 Shared Savings Program Fast Facts (cms.gov).

[2] CMS Announces Increase in 2023 in Organizations and Beneficiaries Benefiting from Coordinated Care in Accountable Care Relationship | CMS. While ACO REACH enrollment is now closed for new ACOs to join, providers can continue to join as participants or preferred providers in existing ACO REACH organizations.

- The ACO REACH Model offers a broader variety of program flexibilities available to participating providers.

4. Are we aligned with our proposed ACO partner's health equity plan?
    - Participants in an ACO REACH program will need to be aware of the health equity plan of its partner ACO and to be prepared to address the considerations in the plan accordingly and the impact of the alignment and benchmarking methodology.
5. Are we prepared for additional compliance & enforcement scrutiny?
    - The Centers for Medicare & Medicaid Services (CMS) is poised to take on an enhanced role in ensuring model compliance among ACO REACH participants, particularly given public scrutiny this model has received.

**Consideration 1 – Opportunities to Participate in Multiple Models**

Under MSSP, an ACO participant is defined as an individual or group of ACO providers/suppliers that are identified by a Medicare-enrolled billing taxpayer identification number (TIN). Therefore, when an ACO participant agrees to participate in MSSP, it does so on behalf of all, not just a subset, of its ACO providers/suppliers that bill under that TIN. For health systems and group practices operating under a single TIN, then, participating in MSSP is an all-or-nothing approach: all individual physicians and other providers/suppliers that bill under that TIN will be included in, and must comply with the requirements and conditions of, MSSP.

In addition, due to statutory limitations of MSSP, all the providers/suppliers billing under the MSSP-participating TIN are excluded from participating in any other Medicare shared savings models. Section 1899(b)(4) of the Social Security Act bars ACOs and participant providers from simultaneously participating in more than one shared savings models "tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings."[3]

Given the variety of specialty-specific shared savings models being tested by CMMI, this MSSP exclusivity provision can lead to tension within multi-specialty group practices billing under a single TIN. For example, while primary care practitioners may prefer continuing in an MSSP model, practitioners in another specialty where CMMI offers a specialty-specific model will be unable to participate in that model, unless it is done through billing under an entirely separate TIN.

Moving from MSSP to ACO REACH is one alternative that could resolve this issue. ACO REACH takes a more specific and narrow route for identifying participant providers. Participant providers within an ACO REACH Organization are identified by the combination of their TIN and National Provider Identifier (NPI) numbers. Therefore, splitting participation within a TIN is permitted, allowing providers who bill through the same TIN to join separate models. So, unlike MSSP, within a single TIN, there can be individual NPIs that are in, or out, of the model.

[3] 42 U.S.C. § 1395jjj.

**Consideration 2 – Regulatory Flexibilities to Incentivize Patient Participation**

MSSP and ACO REACH vary in the flexibilities provided to allow ACOs and their participants to market themselves to beneficiaries and otherwise incentivize beneficiaries to align with an ACO without running afoul of federal healthcare fraud and abuse laws. While both models provide flexibilities, ACO REACH offers significantly more options on this front.

Under MSSP, ACOs participating in certain two-sided risk models[4] may apply to establish and operate a "Beneficiary Incentive Program" (BIP) to provide an incentive payment to each assigned beneficiary to obtain medically necessary primary care services.[5] An ACO that operates a BIP must comply with a series of requirements that establish the parameters of the BIP.[6] The amount of the incentive payment cannot exceed US$20 for each qualifying service,[7] and the amount of the incentive payment must be the same for each eligible beneficiary. The ACO must directly furnish the incentive payments using the ACO's own funds, and cannot shift the cost of the BIP to a federal health care program.[8] An ACO must provide assigned beneficiaries notice of the availability of the BIP using a standardized written notice provided by CMS prior to or at the first primary care visit of the performance year.

Except for the beneficiary notifications required under 42 C.F.R. § 425.304(c)(4)(iii), an ACO in MSSP is prohibited from offering an incentive payment as part of any advertisement or solicitation to a beneficiary or any potential patient whose care is paid for in whole or in part by a federal health care program. Of note, an ACO must exercise care to avoid inducing a beneficiary to voluntarily align with an ACO.[9] ACOs and ACO participants, providers/suppliers, professionals, and other individuals or entities performing functions and services related to ACO activities are prohibited from providing or offering gifts or other remuneration to Medicare beneficiaries to induce, coerce, or otherwise influence a Medicare beneficiary's decision to voluntarily align with an ACO professional.[10]

The incentives flexibilities offered under an ACO REACH Model, in contrast, are more robust. An ACO REACH's, participant providers, preferred providers, and others performing functions or services

[4] Any ACO participating under "Levels C, D, or E" of the "BASIC track", or the "ENHANCED track", is eligible to apply during the MSSP application cycle to establish a BIP, and an ACO that is approved to operate a BIP is required to conduct the program for at least one year. *See* Beneficiary Incentive Program Guidance (cms.gov), pp. 1–2.
[5] 42 C.F.R. § 425.304(c).
[6] Centers for Medicare and Medicaid Services, Medicare Shared Savings Program - Beneficiary Incentive Program Guidance, May 2021 at p. 1. Available here.
[7] *Id*. at p. 3. However, the ACO may "adjust the amount of the incentive payment annually by the percentage increase in the consumer price index for all urban consumers."
[8] *Id*.
[9] ACOs and ACO participants, providers/suppliers, professionals, and other individuals or entities performing functions and services related to ACO activities, are prohibited from providing or offering gifts or other remuneration to Medicare beneficiaries to induce, coerce, or otherwise influence a Medicare beneficiary's decision to voluntarily align with an ACO professional. 42 C.F.R. § 425.402(e)(3).
[10] *Id*.

related to ACO activities are permitted to furnish in-kind, preventative care incentives to beneficiaries if certain conditions are satisfied.

In addition, an ACO REACH organization may elect to participate in the Cost-Sharing Support for Part B Services Beneficiary Engagement Incentive (Cost-Sharing Support Reward Program). Through this incentive, participant providers and preferred providers do not collect beneficiary cost sharing amounts (in whole or in part) from certain categories of aligned beneficiaries and for categories of Part B services identified by the ACO[11], which may include both primary or specialty care services. The ACO REACH organization is then required to make payments to those participant providers and preferred providers who will participate in this beneficiary engagement incentive to cover some or all of the amount of beneficiary cost sharing not collected.

Finally, an ACO REACH organization may also elect to participate in the Chronic Disease Management Reward Program Beneficiary Engagement Incentive (Chronic Disease Management Reward Program), which allows an ACO to provide gift cards to eligible aligned beneficiaries, up to an annual limit of US$75, to incentivize beneficiary participation in a chronic disease management program. ACOs will pay for the gift cards out of their own funds and at their discretion, subject to certain conditions. ACOs that elect to offer this program will be required to submit an implementation plan and maintain records related to the program. An ACO REACH organization will be permitted to tailor its programs to focus on aligned beneficiaries with a specific disease or chronic condition, as long as the program does not discriminate against any aligned beneficiary who would otherwise qualify for participation.[12]

Because the Cost-Sharing Support and Chronic Disease Management Reward Programs are elective and voluntary, a potential participant or preferred provider in an ACO should verify which of these programs an ACO has elected to join as part of the diligence when selecting an ACO partner.

**Consideration 3 – Ability to Take Advantage of Medicare Program Flexibilities**

Both MSSP and ACO REACH also offer benefits to participants in the form of flexibilities in Medicare program requirements. Specifically, MSSP has offered two key program flexibilities: a waiver of the requirement that a beneficiary have a three-day inpatient hospital stay prior to a Medicare-covered, post-hospital, extended-care service when certain conditions are met, and an expanded telehealth benefit allowing (even outside of the public health emergency) beneficiaries to receive telehealth services at home regardless of geographic location.[13]

While ACO REACH also includes those two program flexibilities, it also unlocks several additional benefit enhancements that are not available under MSSP:

- Post-Discharge Home Visits Benefit Enhancement: This benefit enhancement offers a conditional waiver of the requirement for direct supervision to allow payment for certain home visits

[11] Excluding prescription drugs and durable medical equipment, prosthetics, orthotics, and supplies.
[12] CMS, ACO REACH Model, Request for Applications, Feb. 24, 2022, p. 32.
[13] https://www.cms.gov/files/document/shared-savings-program-telehealth-fact-sheet.pdf.

furnished to eligible, non-homebound beneficiaries by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a)(1)) under general supervision, rather than direct supervision, incident to the professional services of physicians or other practitioners that are participant providers or preferred providers.

- Care Management Home Visits Benefit Enhancement: This benefit enhancement offers a conditional waiver of the requirement for direct supervision to allow for payment for certain home visits that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization.
- Home Health Homebound Waiver Benefit Enhancement: Currently, to receive Medicare reimbursement for home health care services, a Medicare beneficiary must be homebound as required by § 1814(a)(2)(C) and § 1835(a)(2)(a) of the Social Security Act. This benefit enhancement targets those beneficiaries with multiple chronic conditions who are at risk of an unplanned inpatient admission using different criteria than set out under Medicare today. Specifically, to qualify for home health services under this waiver, beneficiaries must (1) otherwise qualify for home health services under 42 C.F.R. § 409.42 except that the beneficiary is not required to be confined to the home; (2) meet the eligibility criteria as defined by CMS of at least two chronic conditions; and (3) have one of the three following indicators: inpatient service utilization, frailty, or social isolation.
- Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement: This benefit enhancement eliminates the requirement that beneficiaries who elect the Medicare hospice benefit give up their right to receive curative care (sometimes referred to as "conventional care") as a condition of electing the hospice benefit.[14]
- Nurse Practitioner (NP) Services Benefit Enhancement (available only for program year (PY) 2023): Beginning in PY 2023, this benefit enhancement allows ACOs to increase flexibility in care delivery, improving care coordination for their aligned beneficiary populations. In addition, consistent with state law, NPs can (1) provide the initial certification that a patient is terminally ill and in need of hospice care, (2) certify a beneficiary's need for diabetic shoes, (3) establish, review, and sign a written care plan for a REACH beneficiary's cardiac rehabilitation, (4) establish, review, sign, and date a REACH beneficiary's home infusion therapy plan of care prescribing the type, amount, and duration of infusion therapy services to be furnished to a REACH beneficiary, and (5) make referrals for medical nutrition therapy.

**Consideration 4 – Alignment on Health Equity**

Both MSSP and ACO REACH--and indeed all CMMI models moving forward[15]--have principles of health equity embedded within the models. For MSSP, changes to expand health equity principles within the model were included in the 2023 Medicare Physician Fee Schedule Final Rule,[16] while with ACO REACH, requirements for health equity have been part of the model from the onset. That said, while the models will share certain health equity concepts, including quality adjustments to take into account health equity

[14] This benefit enhancement currently can only be offered by ACOs participating in the ACO REACH Model under the global risk sharing option. ACO Realizing Equity, Access, and Community Health (REACH) Model Request for Application (cms.gov), p. 75.

[15] CMMI, Innovation Center Strategy Refresh White Paper, https://innovation.cms.gov/strategic-direction-whitepaper, p. 18.

[16] A summary of these changes, are included in the CMS fact sheet, available at Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule - Medicare Shared Savings Program | CMS. *See also* 2023 Medicare Physician Fee Schedule Final Rule, 87 Fed. Reg. 69404 (Nov. 18, 2022).

scoring when measuring ACO performance, ACO REACH contains the unique requirement of obligating an ACO to set up and administer a health equity plan. This health equity plan is intended to identify health disparities in the ACO REACH Organization's market and discusses specific actions the ACO will take that are intended to mitigate the identified health disparities. Thus, when joining an ACO REACH Organization as a Participant or Preferred Provider, understanding a partner ACO's Health Equity Plan and its requirements will be important to gauge any new operational requirements to address health equity.

**Consideration 5 – Readiness for Compliance and Enforcement Scrutiny**

The evolution of capitated payments into the ACO REACH Model has carried controversy. The precursor to ACO REACH, the Global and Professional Direct Contracting Model, ended early and was replaced by ACO REACH in part due to stakeholder concerns about the role that third parties (including for-profit third parties) could hold in ACO organizations and whether there was sufficient government oversight of the expenditure of government funds through these capitated models.

To address these concerns, additional guardrails were built into the ACO REACH Model, including an enhanced role of government oversight that moves closer to what has been historically seen in the context of, e.g., Medicare Advantage organizations. Even with these changes, though, members of Congress have continued to express concern about the ACO REACH program, and have encouraged CMS to closely monitor the program and organizations that have been accepted into the program.[17]

Accordingly, participants in the ACO REACH program should be prepared to engage in healthy compliance activities to prevent against, e.g., inappropriate coding practices, misuse of beneficiary data, and anti-competitive behavior, as these practices are likely to receive a level of focus and scrutiny a step beyond what has heretofore been seen in other value-based models, such as MSSP. The various CMS compliance activities to be prepared for, include:

- Record audits and claims analyses;
- Review of demographic data to identify potential discriminatory behavior in marketing activities;
- Interviews of individuals and entities participating in ACO activities;
- Site visits;
- Surveys of beneficiaries and their caregivers;
- Documentation requests, such as surveys and questionnaires; and
- Comprehensive annual audits.

**Conclusion**

As noted above, on top of the consideration discussed in this alert, there are a variety of important financial, quality, and operational differences and challenges associated with each at-risk, capitated model

[17] *See* Letter to CMS Administrator Brooks-LaSure from Senators Warren et al., Dec. 8, 2022 (https://www.warren.senate.gov/imo/media/doc/221208%20ACO%20REACH%20Letter%20to%20CMS%20with%20Signatures.pdf).

that will require careful consideration when evaluating participation options. K&L Gates' Health Care and FDA practice regularly advises stakeholders on shifting to value-based care, including both government payor and commercial models.