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TRANSITIONING FROM ACO REACH TO MSSP?

Key Considerations for Making the Shift

The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model in its current form is scheduled to conclude by the end of the 2026 performance year. Although organizations, such as the National Association of Accountable Care Organizations (NAACOS), are actively lobbying in support of the model[1], it remains to be seen what the Center for Medicare and Medicaid Innovations (CMMI) will do to the model after its official end date of 12/31/2026 – whether to discontinue it altogether, extend it, or transform it into a different model. The incoming administration transition introduces further uncertainty for the model, which began as Direct Contracting during the first Trump administration and was later rebranded as ACO REACH under the Biden administration.

In 2024, there were 122 ACO participants in the ACO REACH model, with approximately 173,000 providers and 2.6 million aligned Medicare beneficiaries. With the model approaching its official end date and no replacement announced yet, ACOs are naturally exploring alternative programs for their providers and beneficiaries. The Medicare Shared Savings Program (MSSP), given its popularity and (somewhat) similar structure, emerges as a logical option for REACH ACOs to consider. In this paper, we summarize the similarities and differences in program design and financial structures between the ACO REACH and MSSP programs and offer insights into the advantages and challenges of transitioning from ACO REACH to MSSP.

Similarities and Differences

Under both ACO REACH and MSSP, ACOs facilitate coordination and cooperation among healthcare providers to improve the quality of care for original Medicare beneficiaries and reduce the rate of growth in costs. For each performance year, ACOs share in a percentage of the savings they generate if the expenditures of the ACO's assigned beneficiaries are below their benchmark by an amount that meets or exceeds a minimum savings rate threshold. There are also quality and health equity components under both programs. We address some of the similarities and differences in the following key areas (see Appendix A for a short summary).

Agreement Period – For ACO REACH, the contract is on a yearly basis. For MSSP, for agreement periods beginning on July 1, 2019, and in subsequent years, eligible ACOs will enter into an agreement period of not less than 5 years.

[1] https://www.naacos.com/press-release-naacos-calls-for-extension-of-aco-reach-after-record-savings-reported-old/

Participating Options – ACO REACH offers three types of participants, standard, new entrants, and high-needs ACOs, based on whether the ACO had experience serving traditional Medicare patients and the complexity of their needs. Within each type, ACOs can elect the Professional option or Global option, with varying degrees of risk sharing. MSSP offers one participating option for all ACOs, however, they can choose different tracks from Basic (tracks A through E) to Enhanced, with varying degrees of risk sharing.

Assignment of Beneficiaries – Both programs use voluntary alignment and claims-based alignment, with voluntary alignment taking precedence.

For both MSSP and REACH, if an eligible beneficiary elects a primary care physician through MyMedicare.gov and the physician is a participating physician with the ACO, then the beneficiary is assigned to the physician for the performance year, regardless of where the beneficiary has received care. REACH has an additional option of Signed-Attestation Based Voluntary Alignment (paper based voluntary alignment.

For claims-based assignment, both programs use the plurality of primary care algorithm and assign an eligible beneficiary to the ACO where the beneficiary has received the most their care from (based on total costs).

An important difference in claims-based alignment is that ACO REACH exclusively uses prospective alignment while MSSP offers two options – prospective alignment as well as prospective alignment with retrospective reconciliation. In prospective alignment, the plurality of services is determined using a look-back period prior to the performance year. This approach allows ACOs to know their beneficiary population at the start of the performance year. For prospective alignment with retrospective reconciliations, beneficiary alignment is updated quarterly using the most recent data, with a final reconciliation conducted after the performance year using the complete dataset. As a result, ACOs do not have certainty about their final beneficiary population until after the performance year ends.

Both programs allow services provided by Advanced Practice Providers (APPs), Nurse practitioners, Physician Assistants and Clinical Nurse specialists to count toward plurality, but MSSP alignment has a pre-step which requires a primary care physician to see the beneficiary in prior 12 months. If the beneficiary does not meet the pre-step attribution requirement services provide by APPs don't count toward plurality.

Provider Participation - Under MSSP, an ACO participant is defined as an individual or group of ACO providers identified by a taxpayer identification number (TIN). Participating providers in REACH are defined by their TIN and National Provider Identifier (NPI) combination. This narrower identification allows REACH more flexibility for participation for subsets of providers within the same TIN.

Benchmark Determination – both programs determine benchmarks based on a combination of ACO historical expenditures, as well as regional expenditures. For ACO REACH, the base years are fixed as 2017 through 2019 for the Standard option, with the weights being 10%, 30%, and 60% respectively. For New Entrant and High Needs ACOs, the benchmarks were based on regional rates only for performance years 2021 through 2024, and for PY 2025 and 2026, a combination of regional rates and ACO's recent

historical expenditures (as recent as 2024). Regional rates and historical rates are blended with a 45% weight on the regional component (increases to 50% in PY 2026) for the Standard option and 50% for the New Entrant and High Needs options.

For MSSP, benchmark years are determined as the most recent three years prior to the start of a new agreement period (each agreement period is at least five years). Benchmark years are weighted 10% (oldest), 30%, and 60% (most recent) for the first agreement period. Benchmark years will update and be weighted equally for the subsequent agreement periods. Instead of blending directly with the regional rates, the differences between the blended benchmark year expenditures and the risk adjusted regional rates are calculated and applied to the ACO benchmarks after applying a weight that varies depending on whether the ACO expenditures are higher or lower than the regional expenditures. The respective weight also increases by the agreement period to a maximum of 50%.

In 2025 REACH will cap the ceiling for the regional adjustment at 3% (down from 5%), while MSSP caps the regional adjustment at 5%. MSSP recently eliminated the negative regional adjustment for new agreement periods, while REACH floors the negative regional adjustment at -2%.

Another key difference is that REACH ACOs participating in the Global option (100% risk sharing) are subject to a benchmark discount. The discount is 3.5% in PY 2025 and 4% in PY 2026. MSSP does not have a similar discount to the benchmarks.

Capitation Payment – ACO REACH offers two capitation mechanisms, primary care capitation and total care capitation. Under primary care capitation, the capitated payment to the ACO applies only to certain primary care services. Under total care capitation, the capitated payment to the ACO applies to all services covered by Medicare Parts A and B.

MSSP does not generally offer capitation. In 2025 CMMI is testing a new model, Primary Care Flex, within the MSSP program that will offer Prospective Primary Care Payments (PPCPs). Low revenue MSSP ACOs can participate in the Primary Care Flex model by starting a new agreement period in 2025. Additionally, in 2026 MSSP is offering Prepaid Shared Savings of up to 50% for ACOs in track C-E or Enhanced with a consistent track record of prior savings.

Advanced payment options are available for REACH ACOs and the MSSP ACOs in Track E of the Basic track and Enhanced track.

Risk Sharing – REACH ACOs assume full risk (100%) under the Global option and partial risk under the Professional option. There is also a risk mitigation mechanism through the application of a risk corridor, where the ACO's share of savings or losses decreases as they move through the corridor.

For MSSP, shared savings and losses increase from the Basic to the Enhanced track, with the highest share being 75%. Tracks A and B within the Basic track are "upside only" with no loss sharing. There are also caps applied to both shared savings and losses, calculated based on a percentage of the benchmark.

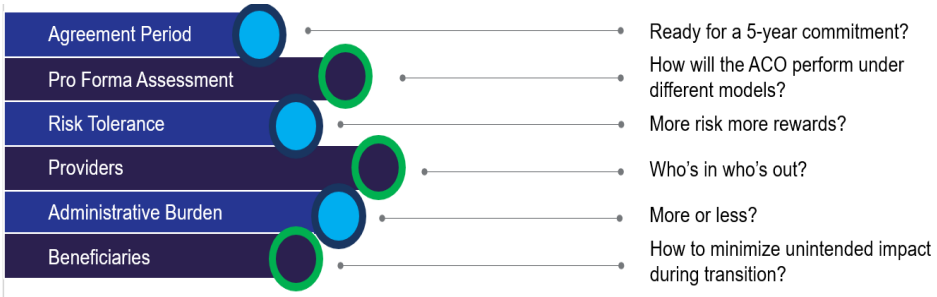
CMS recently requested comments on including a full risk track for MSSP. If such an option materializes, it could help bridge the gap for REACH ACOs that need to transition to MSSP in future years.

Data and Reporting Packages – Both MSSP and REACH provide ACOs with detailed monthly claims through the Claim and Claim Line Feed (CCLF) reporting package. REACH also provides summarized data for risk scores, membership, and expenditures monthly. MSSP only provides summarized data on a quarterly basis.

Medicare Program Flexibility - Both MSSP and ACO REACH offer Medicare program flexibilities, but ACO REACH provides a more extensive set of options. MSSP includes basic flexibilities such as the three-day hospital stay waiver and expanded telehealth benefits. ACO REACH builds upon these by adding several additional enhancements, including relaxed supervision requirements for home visits, expanded home health services for non-homebound patients, concurrent hospice and curative care options, and broader nurse practitioner authorities. These additional flexibilities give ACO REACH participants more tools to deliver care in alternative settings and methods.

Key Considerations

For REACH ACOs considering switching to MSSP after the 2026 performance year or sooner, there are a few key considerations for making the shift, as well as optimization strategies.



Below are a few more detailed considerations.

- Which Track? – REACH ACOs, especially if they have taken the global option, are generally accustomed to risk sharing. When switching to MSSP, they may consider the higher-risk tracks, such as the enhanced track or the higher tracks within the Basic option.

- However, other factors, such as the global discount applied to the REACH benchmarks, need to be considered in comparing the actual shared savings. For REACH ACOs participating in the global track, the global discount in 2026 will be 4%. All else equal, a gross savings of 16% or higher would be needed in REACH to generate more net savings as a % than an equivalent Enhanced MSSP ACO because of the discount. (REACH - 16% - 4% = 12% net, MSSP – 16% * 75% = 12% net)

- Capitation and Provider Payment – with capitation being a common mechanism under ACO REACH, ACOs may have arrangements to pass a portion or the full capitation down to participating providers. With capitation no longer being an option under MSSP, ACOs need to weigh the risks and benefits of continuing any capitation arrangements with downstream providers, and if any modifications may be necessary. ACO Enablers may be an alternative option for capitation in MSSP. ACO Enablers allow smaller scale practices to participate in an ACO without having to make big infrastructure investments. One benefit offered by some Enablers is pre-payment of shared savings when meeting some or all of the Enabler's care management initiatives.

- Alignment Method – under ACO REACH, for claims-based alignment, the only option is prospective alignment. With retrospective reconciliation becoming an option under the MSSP, ACOs need to

weigh the pros and cons of whether to take the option. Prospective alignment allows the ACOs to know their patient population at the beginning of the performance period, providing stability of the benchmark calculation through the performance year. Prospective alignment with retrospective alignment enables more accurate assignment of the members that utilized an ACO's participating providers during the performance year, allowing for the providers to make an impact on the patient population.

- New or Existing MSSP – if an ACO is already participating in the MSSP, they may consider merging its ACO REACH line of business into the existing MSSP or starting a new MSSP. An important consideration is in the determination of historical benchmark years. Since the benchmark years are the three most recent years before the start of each MSSP agreement period, a new MSSP would have more recent years as their benchmark years. If the ACO has achieved considerable expenditure reductions in recent years, switching and starting a new MSSP may put the ACO at the expense of its own good performance in the benchmark determination. In this case, joining an existing MSSP with an older benchmark period may allow for a smoother transition.

- High Needs ACOs – the risk adjustment methodology for High Needs ACOs under REACH uses a concurrent HCC model, customized to the population's unique nature with more complex and evolving health needs. Risk adjustment under MSSP is prospective only. Switching to MSSP will pose additional challenges and changes for high needs ACOs. Comparable high needs populations (benchmarks above $20,000 per capita) participating in MSSP show significantly less savings as % of revenue compared to REACH. The minimum participation for High Needs REACH is 1,000 beneficiaries in PY2025. MSSP has a minimum of 5,000, so High Needs ACOs would need to increase enrollment or join an existing ACO to continue participation.

- Quality report for REACH - includes three claims-based metrics and the CAHPS survey. Beginning with the 2025 performance year, MSSP ACOs must report quality measures via the MIPS Clinical Quality Measure (CQM) collection type or the electronic Clinical Quality Measure (eCQM) collection type. These MSSP reporting options are significantly more burdensome on the ACO than claims-based measures.

- Generally, the data provided to REACH ACOs is superior to the data provided to MSSP ACOs. As a result, an ACO has a greater ability to understand their financial position in REACH compared to MSSP.

Conclusion

It remains to be seen what CMMI will do about the ACO REACH model after its official conclusion date of December 31, 2026, particularly considering the pending administration change in 2025. We expect an announcement to be released in the next few months (early 2025). Whether it will be extended, ended, or replaced with a new model with modifications, switching to MSSP, a well-established flag-ship model remains an option for REACH ACOs. ACOs need to understand the differences and intricacies of both programs, carefully assess the pros and cons, and make decisions that best suit the ACO's particular situation and population.

Please contact the authors with any questions or to follow up on any of the concepts presented here.

Appendix A: Similarities and Differences in Model Design

	ACO REACH	MSSP
Agreement Period	Annual contracts.	Minimum of 5 years.
Participating Options	Standard, New Entrants, High Needs ACOs with varying risk options (Professional or Global).	One participation option with tracks: Basic (A-E) and Enhanced, offering varying risk levels.
Beneficiary Alignment	Voluntary, claims-based, and Signed-Attestation Based Voluntary Alignment.	Voluntary and claims based. No signed attestation option.
Claims-Based Assignment	Exclusively prospective alignment.	Prospective alignment or prospective with retrospective reconciliation.
Provider Participation	Defined by TIN-NPI combinations, allowing more flexibility.	Defined by TIN, offering less flexibility.
Benchmark Determination	Historical years fixed (2017–2019); includes regional and ACO-specific adjustments.	Benchmark years are the three most recent years before the agreement period; adjustments based on plan and regional differences.
Capitation	Offers primary care capitation and total care capitation.	No capitation (testing new models like Primary Care Flex in 2025).
Risk Sharing	Global option: full risk (100%). Professional option: partial risk.	Tracks A-B: upside-only; Tracks C-E and Enhanced: risk-sharing up to 75%.
Medicare Flexibility	Broader options, including home health services for non-homebound patients and concurrent hospice care.	Basic flexibilities like telehealth and a three-day hospital stay waiver.
Data Reporting	Monthly claims data and detailed risk/expenditure summaries.	Quarterly data summaries; less frequent updates.

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