Making MSSP work for High Needs Populations

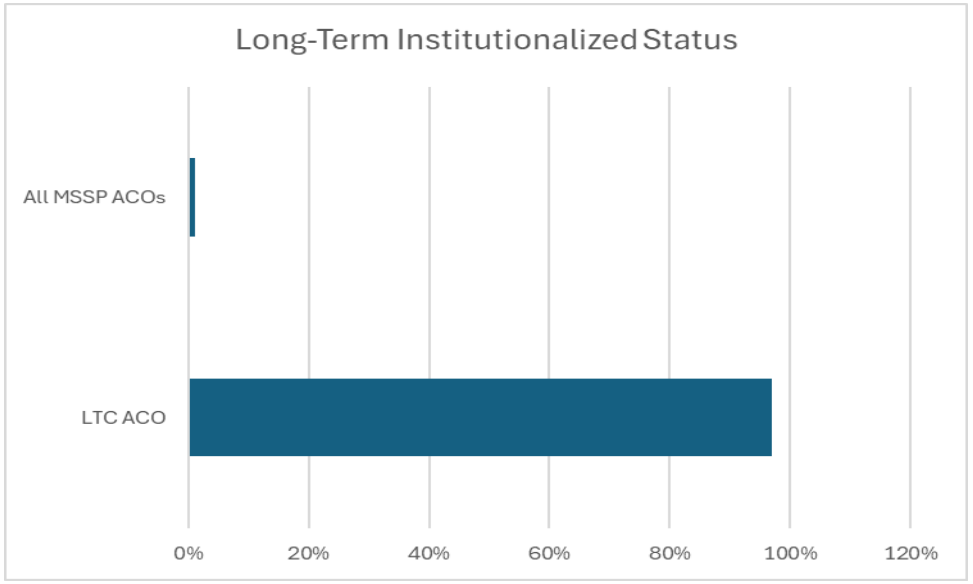
Prepared for NAACOS Fall Conference
Washington DC

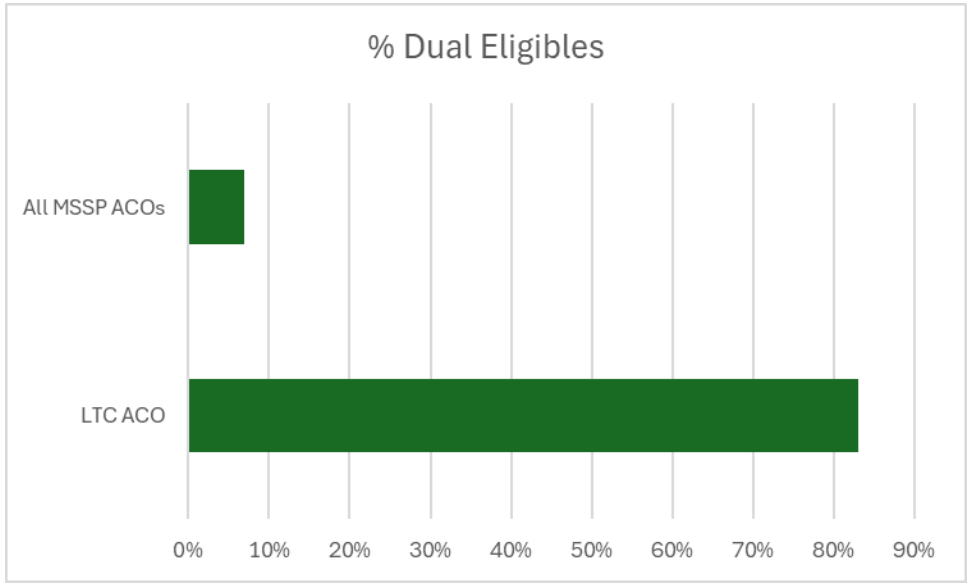
LTC ACO

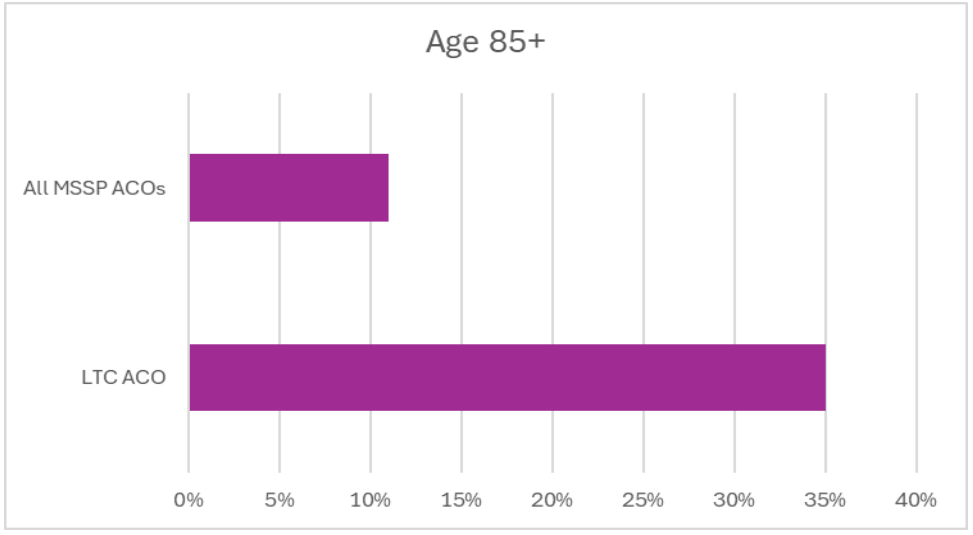
Who We Are

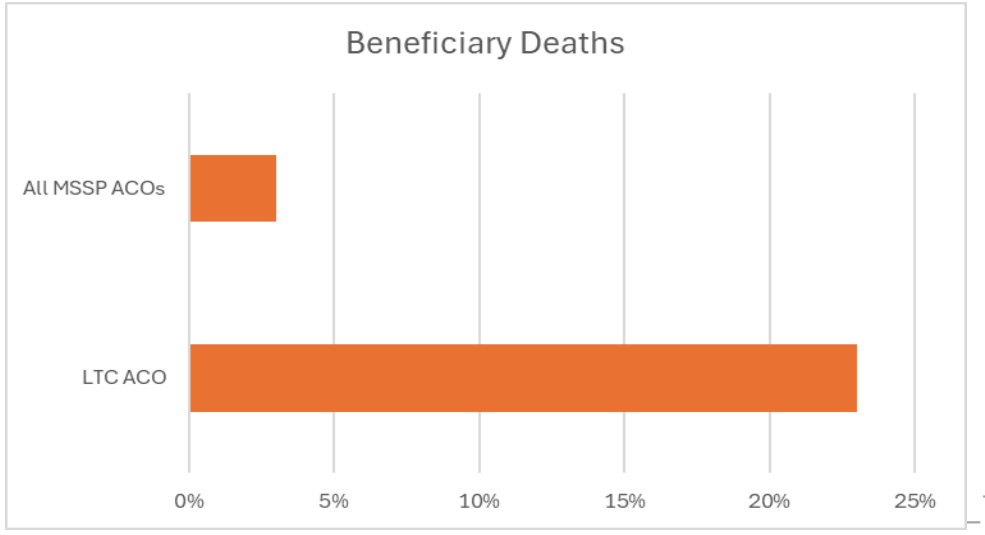
- LTC ACO is a MSSP-only ACO started in 2016 and was the first ACO focused on serving the Medicare FFS population residing in long-term care nursing facilities
- Participated in the lowest track in our first agreement period, then moved to the Enhanced Track in our 2nd and 3rd agreement period
- In 2025 expanded to include beneficiaries residing in Assisted Living Facilities
- In the 2024 settlement, generated savings of ~$6,500 per beneficiary
- As of 2024 settlement, there are 6 MSSP ACOs with >60% LTI population:
  - > 80k lives
  - $3.6 billion in Medicare benchmark spend ($45k annual per beneficiary)
  - $300 million in 2024 generated savings

Unique and Complex Population









Key Areas of Focus

Care Delivery

- Unplanned hospitalizations / readmission
  - Custom predictive analytics powered to identify beneficiaries at greatest risk
  - Intensified primary care services for those at greatest risk
  - Enhanced transition of care follow up
  - Reducing pharmacy burden – Drive to Deprescribe
- Mortality
  - Advance care planning for all beneficiaries, with priority on patients with highest risk
  - Determine the appropriate use of palliative care and hospice care

Attribution

- Satisfying physician visit in a setting where APPs are often primary
- Understanding plurality interference from other providers - CCM, Behavioral Health and Wound Care (NPs)

Quality

- Prioritize early interventions based on high rate of mortality
- Appropriate documentation of eligible exclusions (66+ with evidence of frailty and advanced illness diagnosis/dementia medication)

Unique Challenges

- Quality Metrics & Measurement
  - Movement to Universal Foundation Set includes measures that are not relevant to the population (e.g. breast cancer screening), producing unintended harm in end-of-life populations inconsistent with goals of care; no exclusion for patient refusal, harm, or shared-decision making medical exceptions
  - Proposed elimination of Health Equity Adjustment Bonus Points for Quality (not understanding the value to LTC ACOs that earn 5-20 points less than average ACOs due to innate population challenges)
  - CAHPS is not appropriate for this population, which CMS recognizes in Medicare Advantage I-SNPs, but not MSSP
- Financial
  - Prior savings cap is not risk adjusted; Population Benchmark Adjustment (fka HEBA) should be additive
  - No concurrent risk model like High Needs ACO REACH
  - Skin substitutes abuse disproportionately impacts long-term care populations
- Attribution
  - Physician visit requirement creates structural attribution obstacle for NP groups
  - Lack of NP specialty creates material attribution interference for primary care providers
  - Lack of insight into prospective assignment conflicts with other ACOs at the beneficiary level
- General Program Structure/Methodologies
  - Primary Care Flex excludes providers in long-term care nursing facilities
  - COVID 19 cost exclusions didn't include direct to SNF admissions

Advocacy Priorities

LTC ACO

High Needs Track within MSSP to address unique challenges

- Quality measure simplification / relevant to end-of-life populations (or add quality points adjustment for ACOs serving high risk populations at end-of-life)
- Attribution simplification – removal of physician visit requirement / exclusion of specialty NP services from primary care attribution methodology
- Paper-based voluntary alignment, allowing alignment mid-year
- Concurrent Risk Adjustment
- Administrative benchmarks to avoid benchmark ratchets in highest saving ACOs
- Capitation/Prepayment mechanism that is not overly burdensome for retrospectively aligned ACOs, that does not exclude long-term care providers, and that does increase costs through mandated new benefits while not increasing benchmarks accordingly

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Get to Know Wellvana

Our mission: make primary care life-changing.

Basic Facts

- **Largest enabler** of hospital-led and rural MSSP ACOs in the nation
- **$12.5 billion** of medical spend, supporting partners coast to coast
- **828K** patient lives and **>500** ACO clients
- 13 MSSP ACOs, 3 REACH ACOs, and significant Medicare Advantage presence

Preliminary PY2024 MSSP Results

- Wellvana ACOs collectively saved Medicare **$327M**
- Out-performed other hospital-led ACOs in key quality care metrics incl. depression screenings and 30-day readmit rates
- Largest ACO achieved the single **highest savings of all MSSP ACOs**, generating a total savings of $169M