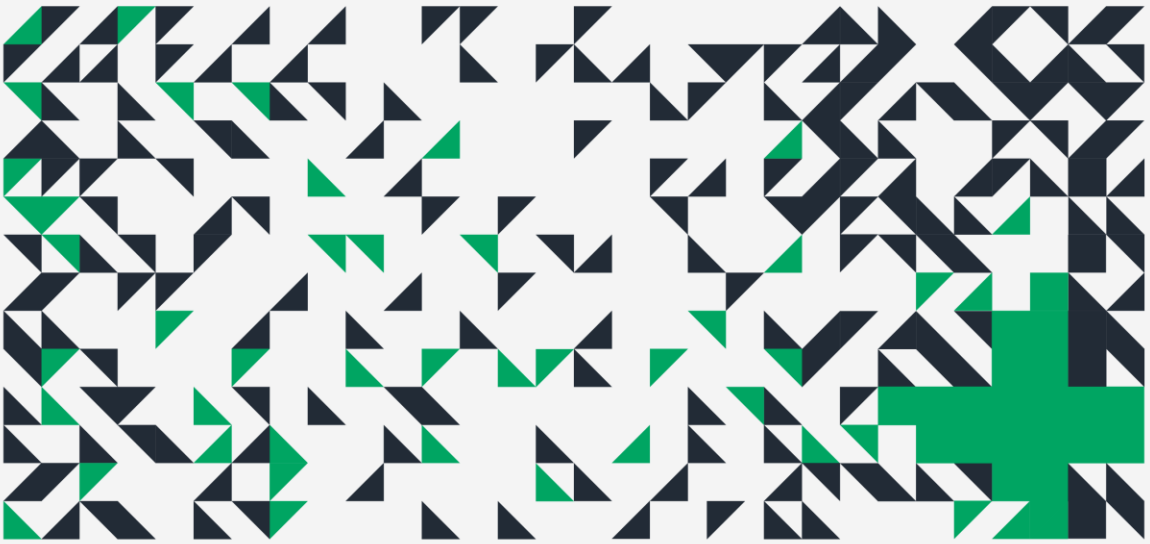
MILLIMAN RESEARCH REPORT

Medicare Shared Savings Program: ACO financial results for 2022

April 2024

Matthew Smith, FSA, MAAA
Brent Jensen, FSA, MAAA
Jacob Anderson
Korye Lockett



Milliman

Table of Contents

Introduction

The primary purpose of this report is to provide timely and relevant insights about the state of the Medicare Shared Savings Program (MSSP) accountable care organization (ACO) market.

Over the last decade, ACOs have emerged as a major player in the healthcare industry. The ACO model aims to provide a structure for better coordinated, more efficient care and, by doing so, reduce overall healthcare expenditures by combining care delivery with financial incentives for efficiency and quality.

Although various forms of "accountable care" have existed for decades, the Centers for Medicare and Medicaid Services (CMS) has been a significant driver of the modern ACO structure and the promulgation of this payment arrangement nationwide.

Today, Medicare fee-for-service (FFS) ACOs exist in every state, representing a wide variety of provider arrangements. While other programs such as ACO Realizing Equity, Access, and Community Health (REACH) exist, the largest ACO program is currently MSSP. As of January 2024, there were 480 MSSP ACOs operating in all 50 states and the District of Columbia, serving nearly 11 million Medicare beneficiaries.[1]

Out of the 60 million total Medicare beneficiaries,
about 18% of beneficiaries are attributed to an MSSP ACO[2]

Given that MSSP ACOs represent such a large portion of the Medicare FFS landscape, it is worthwhile to identify trends and patterns by looking at how ACOs have performed and evolved over time. These patterns and trends can help ACOs better understand what MSSP features may be associated with financial success. It is just as important to see what factors are not correlated with success or failure in the program.

In order to provide insights on these drivers, this report analyzes and summarizes the calendar year (CY) 2022 experience for ACOs under MSSP as reported by the 2022 Shared Savings Program (SSP) ACO Public Use Files (PUFs), published by CMS.[3] This report also references previous PUFs, from 2015 to 2021, highlighting key MSSP trends and patterns in shared savings/(loss) rates, participation, and other key metrics.

Special considerations by year

Many of the past few years saw particularly unusual circumstances that should be considered when evaluating financial results over this time period. They include:

- 2019 was the first partial year of Pathways to Success and featured midyear track changes and new ACO entrants on July 1, when typically new entrants and track changes happen on January 1.
- 2020 was unusual due to the COVID-19 pandemic, and ACO financial results may have been materially impacted by the introduction of Pathways to Success in July 2019 as well as ACOs' protection from downside loss due to continued public health emergency (PHE) provisions.[4]
- In 2021, no new ACOs were allowed to enroll, and CMS's modifications to MSSP rules and regulations during the pandemic continued.

Additional information

The primary financial metric analyzed for this report is the gross savings/(loss) rate. The gross savings (or losses) represent the total dollars saved (or lost) by an ACO against CMS's benchmarks. This amount is distinct from the net savings, which represent the portion of the gross savings shared with the plans; the net savings also depend on the

[1] Centers for Medicare and Medicaid Services (January 1, 2024). Shared Savings Program Fast Facts. Retrieved March 28, 2024, from https://www.cms.gov/files/document/2024-shared-savings-program-fast-facts.pdf.

[2] 60 million value from Kaiser Family Foundation. Medicare Advantage in 2023: Enrollment Update and Key Trends. Retrieved March 28, 2024, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

[3] Centers for Medicare and Medicaid Services. Performance Year Financial and Quality Results. Retrieved March 28, 2024, from https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results.

[4] Centers for Medicare and Medicaid Services (November 4, 2020). Medicare Shared Savings Program: CMS Flexibilities to Fight COVID-19. Retrieved March 28, 2024, from https://www.cms.gov/files/document/covid-ifc-2-medicare-shared-savings-program.pdf.

tier, quality rating, and other factors. In this research report we will use "gross savings" and "savings" interchangeably; net savings will be explicitly referred to as such where relevant.[5] Results are summarized on a composite basis for all ACOs except where otherwise noted.

Additional selected metrics focus primarily on values that underlie or correlate with the savings rates. The methodology and formulas behind these metrics are documented by CMS.[6]

Some ACOs may be excluded from the PUF data, and therefore from our analysis for the following reasons:

- The ACO participated in a non-MSSP Medicare model, such as Next Generation, Pioneer, Direct Contracting, or REACH.
- The ACO did not participate in any Medicare model (such as a commercial-only ACO).
- The ACO was new to MSSP in 2023 or 2024, or terminated before 2015.

The PUF data as well as our analysis excludes all non-Medicare results for ACOs that participate in multiple lines of business such as commercial or Medicaid.

We also have additional ACO-specific information that can be provided upon request. This data includes a list of each MSSP ACO in the PUFs between 2015 and 2022, along with their CMS-provided IDs, their states, initial start dates, and risk tracks for each year from 2015 through 2022, as well as performance data including 2022 beneficiary count, provider count, quality score, average population risk score, benchmark, and savings rate.

Upcoming or ongoing MSSP changes

While a detailed discussion about additional changes that will (or may) start affecting MSSP ACOs in 2024 or later is outside the scope of this research report, ACOs should nevertheless be aware of these changes and potential impacts on their organizations or the overall nationwide MSSP market. We list some of these changes below, along with links to papers discussing them in greater detail:

- The introduction of a new Hierarchical Condition Category (HCC) model for 2024 payments in both Medicare FFS and Medicare Advantage[7]
- Multiple rule changes implemented in the 2023[8] and 2024[9] Medicare Physician Fee Schedule
- The new Guiding an Improved Dementia Experience (GUIDE) model for dementia care,[10] and the new All-Payer Health Equity Approaches and Development (AHEAD) model[11]
- The release of shadow bundles data to ACO participants[12]

Additional changes may be on the horizon with the REACH model set to end in December 2026.

[5] From the PUFs we use as gross savings the variable "sav_rate," which CMS defines as "Total Benchmark Expenditures Minus Assigned Beneficiary Expenditures as a percent of Total Benchmark Expenditures."

[6] Centers for Medicare and Medicaid Services (January 2022). Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology: Specifications, Applicable to Performance Years Starting on January 1, 2022. Retrieved March 28, 2024, from https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-1. Note that CMS has published updated guidance effective 2023.

[7] Pipich, R., Cross, K., & Rothschild, M. (February 2023). High-Level Impacts of the Proposed CMS-HCC Risk Score Model on Medicare Advantage Payments for 2024. Milliman White Paper. Retrieved March 28, 2024, from https://www.milliman.com/en/insight/analysis-of-2024-cms-proposed-hcc-model.

[8] Smith, C., Champagne, N., & Gusland, C. (December 2, 2022). A Summary of the Impactful MSSP Rule Changes in the 2023 Medicare Physician Fee Schedule Update. Retrieved March 28, 2024, from https://www.milliman.com/en/insight/impactful-mssp-rule-changes-2023-mpfs.

[9] Smith, C., Champagne, N., & Gusland, C. (July 27, 2023). Early Thoughts on Proposed Medicare Physician Fee Schedule Changes. Milliman White Paper. Retrieved March 28, 2024, from https://www.milliman.com/en/insight/early-thoughts-on-proposed-mpfs-changes-cms-mssp.

[10] Smith, M., Champagne, N., Eaton, R., Gu, N., & Britt, G. (December 2023). Should Providers Steer Toward or Away From GUIDE? Milliman White Paper. Retrieved March 28, 2024, from https://www.milliman.com/en/insight/should-providers-steer-toward-or-away-from-guide.

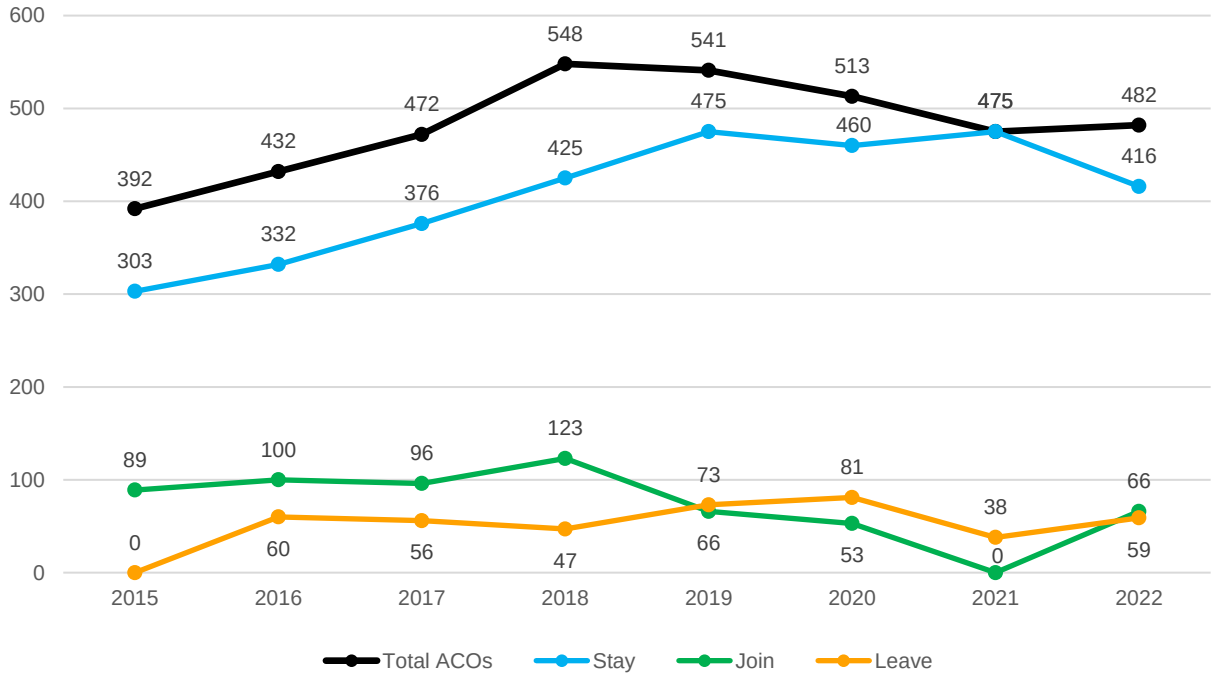
[11] Byron, D., Platt, B., & Champagne, N. (January 3, 2024). What's CMS's AHEAD Model? Retrieved March 28, 2024, from https://www.milliman.com/en/insight/whats-cms-ahead-model-state-agencies-interested-in-tcoc.

[12] Alston, M., Champagne, N., DiNinno, D., Kramer, E., & Murphy, C. (February 13, 2024). Shadow Bundles: A Big Opportunity for MSSP and REACH ACOs. Milliman White Paper. Retrieved March 28, 2024, from https://www.milliman.com/en/insight/shadow-bundles-big-opportunity-mssp-reach-acos.

The MSSP ACO market

Figure 1 shows the total number of ACOs in the market in each year from 2015 through 2022, as well as the total number of ACOs that joined, stayed, or left MSSP. Note that there were no new ACOs in 2021, when CMS paused the ability for ACOs to renew (or begin) their participation agreement.

FIGURE 1: ACO PARTICIPANTS BY YEAR

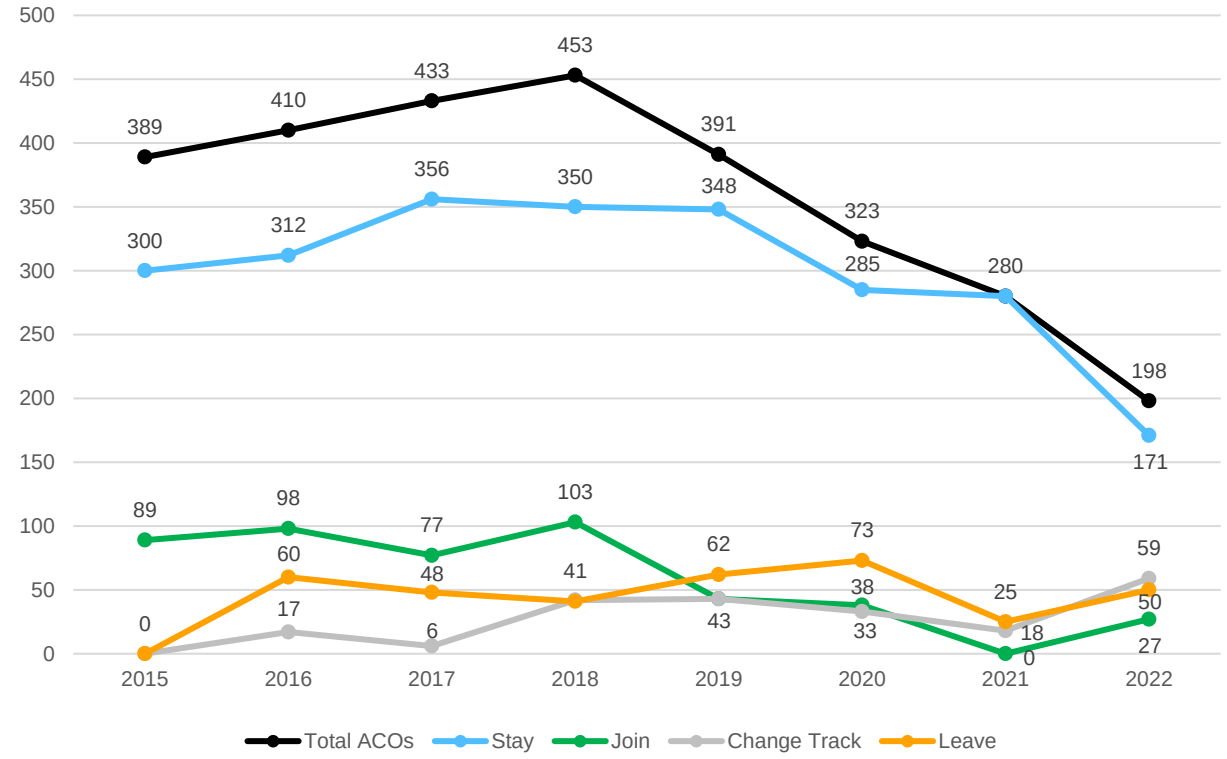


We can also examine the movement in ACOs based on risk track. Through 2019, the majority of all MSSP ACOs were participating in a Track 1 (upside-only) model, and Pathways to Success has added two new upside-only tracks: Basic A and Basic B. However, from 2019 (the start of Pathways to Success) onward, MSSP has seen a rapid shift away from upside-only models such as Track 1. This is due to two factors:

1. The original MSSP rules stated that ACOs could only remain in Track 1 for six years, meaning that the oldest ACOs are now required to leave Track 1.
2. The Pathways to Success program required all new or renewing ACOs to apply for a Basic or Enhanced track starting in 2019; as ACO contracts were set for three years before the introduction of Pathways to Success, renewing ACOs had to depart Track 1 in 2019, 2020, or 2022 (because CMS delayed renewals that otherwise would have happened in 2021).

In Figure 2, we follow the rate of upside-only ACOs, inclusive of the two new tracks.

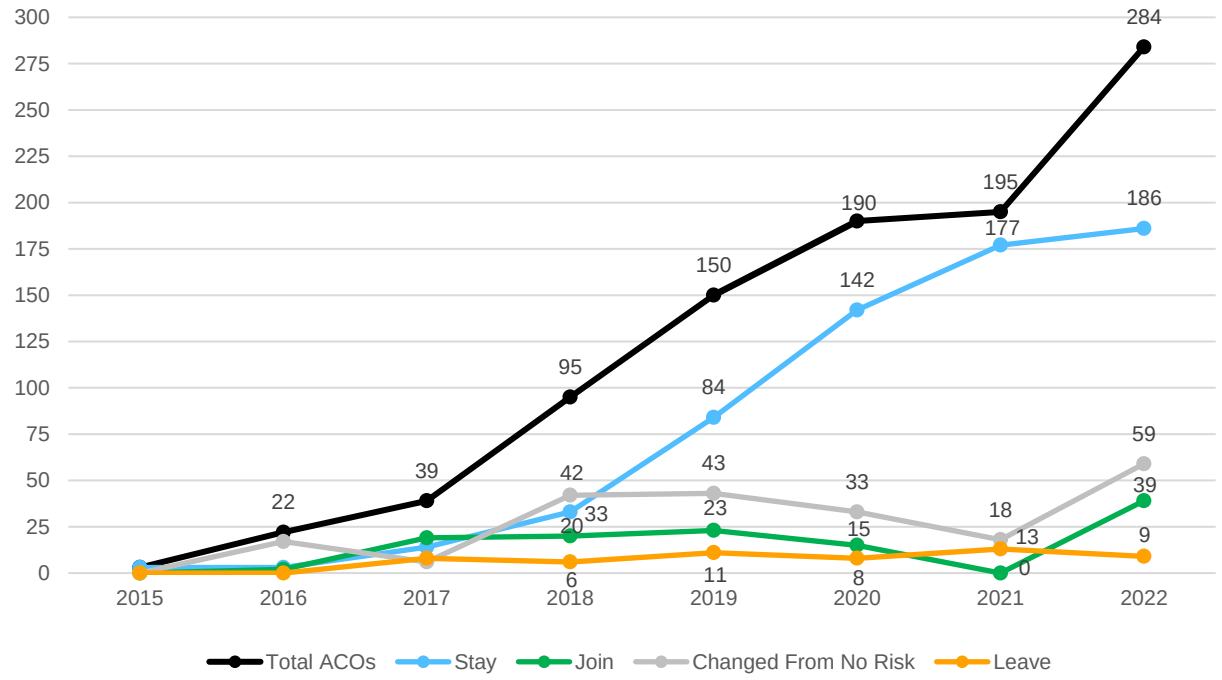
FIGURE 2: UPSIDE-ONLY ACO PARTICIPANTS BY YEAR



As Figures 1 and 2 illustrate, much of the overall decline in the number of participating ACOs between 2018 and 2022 has been driven by ACOs in upside-only risk tracks leaving the program, possibly to avoid taking on downside risk under the Pathways to Success model. Note that, effective January 1, 2023, ACOs already in the Basic glide path under Levels A or B (both upside-only) will have the option to continue their current levels for the remainder of their agreements.

Meanwhile, as Figure 3 illustrates, the number of ACOs already participating in some form of downside risk has been growing steadily over time (with minimal withdrawals) and has grown significantly since the introduction of the Pathways to Success model, where ACOs were transitioned over time to taking on downside risk.

FIGURE 3: ACO PARTICIPANTS WITH BOTH UPSIDE AND DOWNSIDE RISK BY YEAR



We can also observe that the rate of ACOs with two-sided risk leaving the program has been consistently low even as the total number of two-sided participants has rapidly increased.

The inverse pattern can be observed in the upside-only tracks; from 2018 to 2022, the number of leavers was similar to the number of leavers in the 2015-2017 period, even as the total number of remaining ACOs in upside-only tracks has shrunk. We do note that 2021 was an exception to the trend (with notably fewer ACOs leaving upside-only tracks), which could have been caused by a number of factors potentially including the removal of downside risk through the public health emergency, CMS delaying contract renewals, or other factors.

As part of the 2023 Medicare Physician Fee Schedule, CMS has introduced some changes to the risk tracks, including an opportunity for some ACOs to remain in upside-only risk models for the remainder of their agreement periods and making the Enhanced risk track purely optional. These changes are designed to slow the transition to downside risk for currently participating ACOs and potentially to open the door for more MSSP participation from ACOs that may be apprehensive about downside risk.[13]

As noted above, we can distinguish ACOs based on the level of downside risk taken. In addition to breaking out upside-only ACOs, we have organized them separately based on the level of downside risk taken, as follows:

- **No risk**: No shared losses or downside risk (i.e., upside only).
- **Low risk**: Maximum shared losses at or below 10% of benchmark.
- **High risk**: Maximum shared losses above 10% of benchmark.

[13] Smith, C., Champagne, N., & Gusland, C. (December 2, 2022), op cit..

We provide additional detail in Figure 4.[14]

FIGURE 4: MSSP TRACK DETAIL

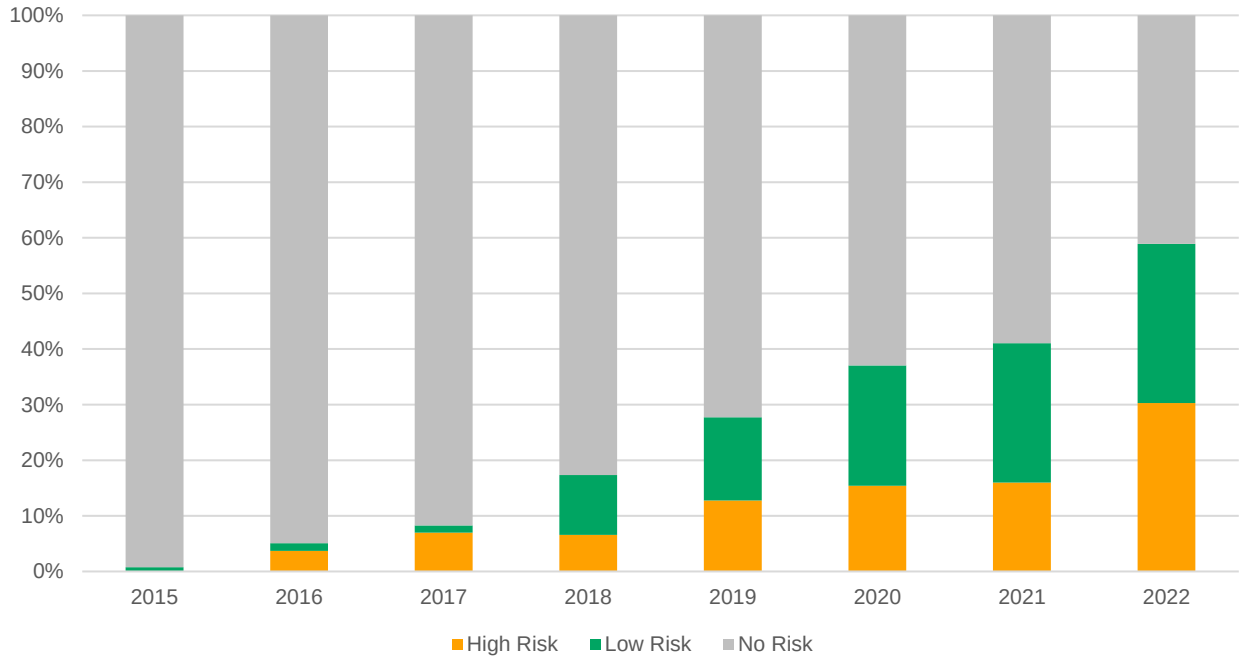
	Pre-Pathways to Success				Basic Track				Enhanced Track
	Track 1	Track 1+	Track 2	Track 3	Level A/B	Level C	Level D	Level E	
Risk Level	No Risk	Low Risk	Low Risk	High Risk	None	Low Risk	Low Risk	Low Risk	High Risk
Available to New Entrants	No	No	No	No	Yes	Yes	Yes	Yes	Yes
Max Shared Savings Rate	50%	50%	60%	75%	40%	50%	50%	50%	75%
Max Savings as % of Benchmark	10%	10%	15%	20%	10%	10%	10%	10%	20%
Max Shared Losses Rate	n/a	30%	60%	75%	n/a	30%	30%	30%	75%
Max Losses as % of Benchmark	n/a	4%	5-10%	15%	n/a	1%	2%	4%	15%

Using these categories, we can also observe the changing distribution between MSSP risk levels through 2022.

As with Figures 2 and 3 above, we observe an expansion of risk-taking ACOs over time, either as a result of program requirements to move toward taking downside risk or ACOs being more inclined to take downside risk with greater upside potential.

[14] Pre-Pathways to Success values obtained from: Centers for Medicare and Medicaid Services (July 2017). Fact Sheet: New Accountable Care Organization Model Opportunity: Medicare ACO Track 1+ Model. Retrieved March 28, 2024, from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf. Basic and Enhanced values obtained from: Centers for Medicare and Medicaid Services (May 2022). Basic and Enhanced values from CMS Shared Savings Program Participation Options for Performance Year 2024. Retrieved March 28, 2024, from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf. We also note that Figure 4 above represents a simplification of the shared savings rates. Additional factors can apply such as quality rates and overall revenues.

FIGURE 5: ANNUAL DISTRIBUTION OF ACOS BY TRACK



In addition to distribution across risk tracks, ACOs can vary substantially in terms of numbers of beneficiaries served, with most ACOs having between 5,000 and 25,000 beneficiaries in 2022. Overall, the number of beneficiaries attributed to an ACO increased from 2015 to 2019 but has decreased in 2020 and 2021 before increasing again in 2022. Figure 6 shows the number of ACOs by 2022 beneficiary levels. Figure 7 shows the total assigned beneficiaries by year.

FIGURE 6: DISTRIBUTION OF ACOS BY 2022 BENEFICIARY LEVELS

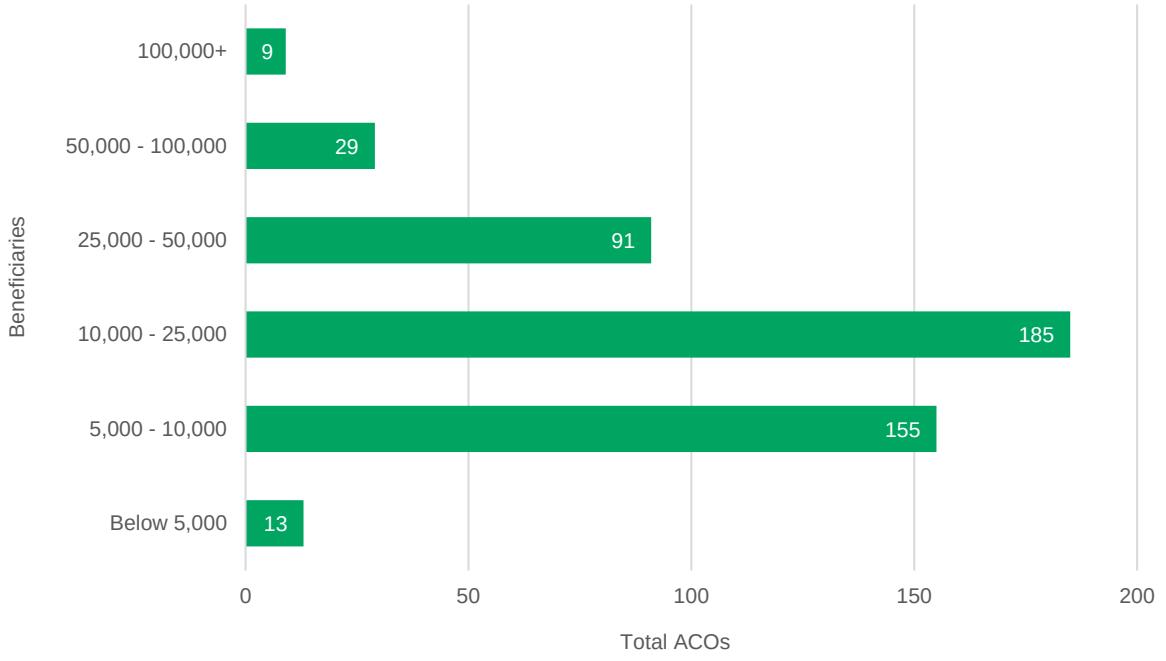
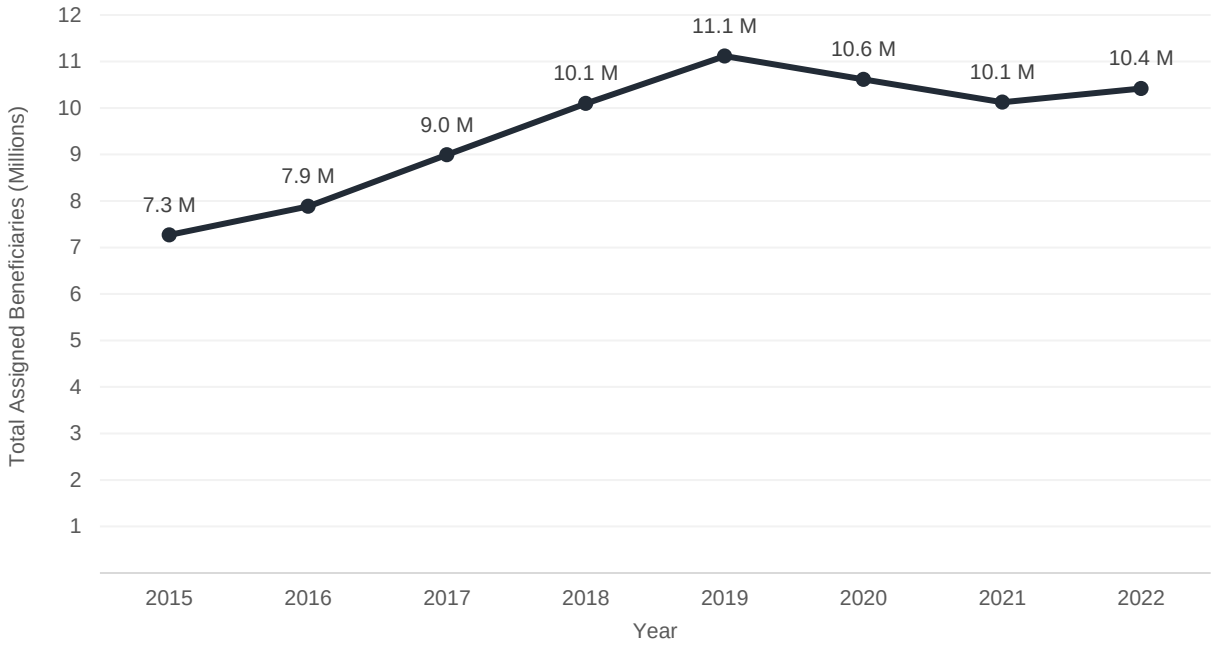
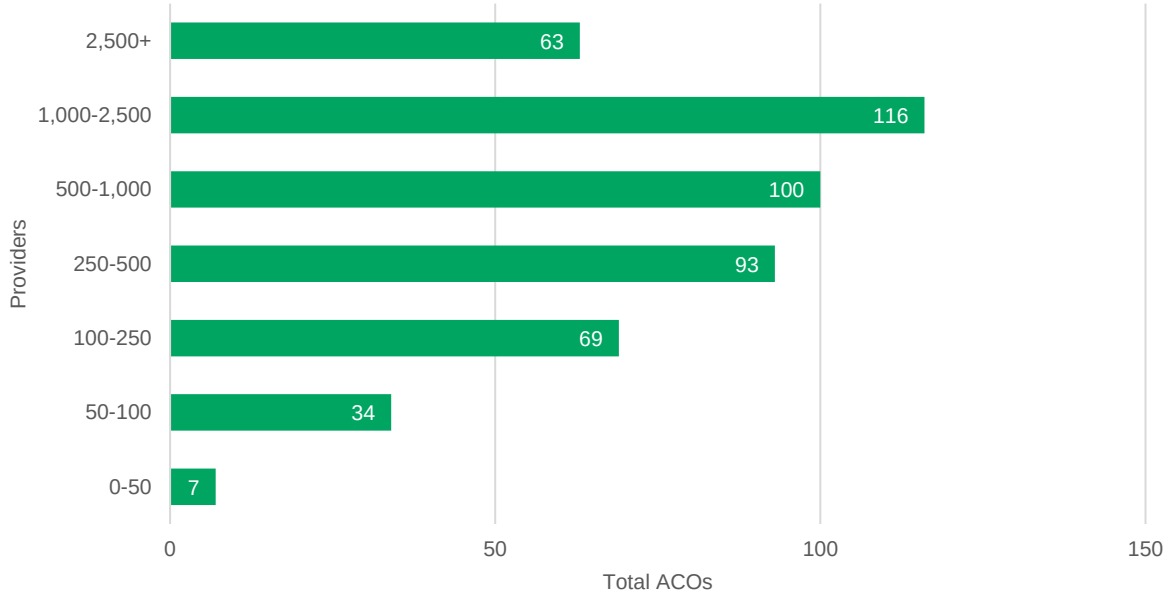


FIGURE 7: TOTAL ASSIGNED BENEFICIARIES BY YEAR



Another way to examine the distribution of ACOs by size is provider count, based on the number of National Provider Identifiers (NPIs) contracted with an ACO, as shown in Figure 8.[15]

FIGURE 8: DISTRIBUTION OF ACOS BY 2022 PROVIDER COUNT



[15] The count of providers defined in the PUFs is "based on the ACO's certified participant list used in financial reconciliation and information in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)." This count of providers is on a per-NPI basis.

Pathways to Success review

Starting July 2019, CMS implemented Pathways to Success, a redesign of MSSP with the goal of encouraging ACOs to transition to performance-based risk more quickly, as well as to increase savings for the Trust Funds.[16]

Given the incidence of the COVID-19 global pandemic in early 2020, it is difficult to separate out the influence of each contributor to ACO financial performance. Nevertheless, now that we have data through 2022, a reasonable analysis of the impact of Pathways to Success is possible. We present the results of this analysis below. Please note that, for simplicity, our analysis combines ACOs that rebased or joined MSSP in 2019 and 2020.

ADOPTION OF PATHWAYS TO SUCCESS

Due to CMS contracting rules, all MSSP ACOs are now required to be in a Pathways to Success contract, rebasing or joining the program in either July 2019, January 2020, or January 2022.

PATHWAYS TO SUCCESS PERFORMANCE IMPACT

Figure 9 shows gross savings for the 2018-2022 period for ACOs based on whether they were new in 2019 or later, and whether they had a Pathways to Success contract in 2019 or 2020 or whether their first such contract was in 2022.[17]

FIGURE 9: PERFORMANCES LEVELS BY PATHWAYS TO SUCCESS NEW/REBASING STATUS

	Number	2016	2017	2018	2019	2020	2021	2022
ACOs Rebasing in 2019/2020	208	1.6%	1.9%	2.7%	3.7%	5.2%	4.4%	4.7%
ACOs new in 2019/2020	97				1.8%	3.9%	3.1%	3.8%
ACOs new in 2022	66							2.8%
ACOs Not Rebasing in 2019/2020	111	-0.3%	1.2%	0.8%	1.7%	2.5%	2.7%	2.4%
All MSSP ACOs	482	1.2%	1.8%	2.1%	3.0%	4.3%	3.8%	3.9%
Difference between ACOs Rebasing and not in 2019/2020		1.9%	0.7%	1.9%	2.0%	2.6%	1.7%	2.3%

There are a few notable observations that can be drawn from Figure 9. First, as expected, the COVID-19 pandemic clearly had a material impact on gross savings, with gross savings in the 2020-2022 period across the board higher than in the 2016-2019 period for each cohort. And second, the class of ACOs that entered Pathways in 2019 or 2020 had disproportionally high savings compared to the non-joining ACOs.[18]

However, this data also suggests that Pathways itself may have had an overall positive impact on ACO savings rates, considering that rebasing ACOs had a 2.1% higher savings rate than non-rebasing ACOs in the 2019-2021 period, above the 1.5% average difference in the 2016-2018 period. We caveat this observation by noting that all MSSP ACOs were in Pathways in 2022, and there remained a material gap between the cohorts, but the improvement in the 2019-2021 period remains notable.

[16] Centers for Medicare and Medicaid Services (December 21, 2018). Fact Sheet: Final Rule Creates Pathways to Success for the Medicare Shared Savings Program. Retrieved March 28, 2024, from https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program.

[17] Please note that the "All MSSP ACOs" savings rates shown here differ from those shown in Figure 14: Average gross savings rate by year. The reason for this difference is that in this section, we use straight averaging by ACO, whereas Figure 14 uses dollar-weighted averaging.

[18] As illustrated in Figure 11 below, the ACOs that joined Pathways early had disproportionally low savings rates in the preceding years.

We can also evaluate new ACOs as compared to incumbent ACOs. As we discuss later in the research report, ACOs have historically experienced worse gross savings results in their first few years in the program. However, while this gap held true as compared to ACOs that rebased in 2019 or 2020, new 2019/2020 MSSP ACOs as a class outperformed the non-rebasing incumbents in each of 2019, 2020, and 2021; this outperformance also persisted in 2022, when the remaining non-rebasing incumbents all joined Pathways.

Two cautionary notes exist, however: first, the incumbent ACOs late to join Pathways to Success did not experience improvement levels similar to other cohorts between 2021 and 2022; and second, ACOs new in 2022 underperformed the other cohorts that had already joined Pathways in 2019 or 2020. These cohorts will be worth keeping an eye on in future years to determine whether their performance levels improve to match the other cohorts or if they overall continue to lag behind.

We also note that it is unclear to what extent the observed performance improvement was due to Pathways to Success per se, whether the Pathways benchmarks were relatively more favorable in 2020 or relatively less favorable in 2022, whether the performance improvement is due to organizational characteristics that made joining Pathways more likely in the first place, or whether there are yet other drivers that should be considered in such a discussion.

We therefore advise caution when interpreting these results; the data overall suggests that Pathways to Success had an overall net positive impact on the gross savings rates of ACOs, but there may be more to the story. To help illustrate things further, we provide a deeper dive into the Pathways to Success and rebasing data throughout the rest of this section.

INITIAL VS. REENTERING ACOS

In 2019 and 2020, nearly 100 ACOs joined MSSP. This included a substantial number of both initial and reentering MSSP ACOs (the latter having left MSSP at some point in the past). We show the gross savings results for these two cohorts for the second half of 2019 through the end of 2021 in Figure 10.

FIGURE 10: GROSS SAVINGS LEVELS OF NEW MSSP ACOS BY TYPE

	Number	2019	2020	2021	2022
Initial	55	2.2%	4.0%	3.1%	3.9%
Re-Entering	42	1.1%	3.9%	3.1%	3.7%
All New ACOs	97	1.8%	3.9%	3.1%	3.8%
All ACOs	482	2.7%	4.2%	3.7%	3.7%

The initial ACOs materially outperformed the reentering ACOs in 2019 and performed very similarly to reentering ACOs in the 2020-2022 period.[19] We caution against reading too much into these results, but they are notable given the general historical tendency for newer ACOs to underperform incumbent ACOs.

EARLY RENEWALS IN 2019 AND 2020

One important option CMS allows ACOs is early contract renewal (or “rebasing”). ACOs that use this option may do so for many different reasons, such as wanting to move up the risk pathway sooner (in the case of favorable performance) or update benchmarks to account for recent claims (in the case of adverse performance) and risk score growth.

In either July 2019 or January 2020, 236 MSSP ACOs renewed their contracts; 23 of them joined Pathways by rebasing early.

[19] Among ACOs new in 2019, initial ACOs outperformed reentering ACOs in each year of the 2020-2022 period, while among ACOs new in 2020 the reverse was true

Additionally, in 2022 140 MSSP ACOs renewed their contracts. Of them, 29 were MSSPs already in Pathways to Success that elected to rebase early, with 26 of the early renewals involving a shift from a Basic track to Enhanced (two were Enhanced to Enhanced, and the other was Basic B to Basic E). Additionally, there were four MSSP ACOs that renewed early in both 2019 or 2020 and in 2022.

In Figure 11, we evaluate the gross savings levels of these early-rebasing ACOs.

FIGURE 11: GROSS SAVINGS RATES BY 2019/2020 EARLY RENEWAL STATUS

	Number	2016	2017	2018	2019	2020	2021	2022
ACOs Rebasing early in 2019/2020	19	3.3%	1.0%	0.2%	0.7%	5.9%	5.1%	5.5%
ACOs Rebasing normally in 2019/2020	189	1.5%	2.0%	3.0%	4.0%	5.1%	4.4%	4.6%
ACOs Not Rebasing in 2019/2020	111	-0.3%	1.2%	0.8%	1.7%	2.5%	2.7%	2.4%
All ACOs in MSSP Before Pathways	319	1.2%	1.8%	2.1%	3.0%	4.3%	3.8%	3.9%

The cohort of 19 ACOs that rebased early in 2019 or 2020 experienced tremendous success in the 2020-2022 time period, despite overall relatively poor performance levels from 2016 to 2018.[20] Indeed, despite their collective underperformance pre-Pathways, they outperformed the ACOs that rebased on a normal timetable in each year of 2020 through 2022.

We do note that this is a relatively small cohort of only 19 ACOs, but the performance of this class of ACOs is nevertheless striking, improving gross savings by about 5%, when MSSP ACOs as a whole improved by closer to 2.5% in the same time period. For this cohort, the decision to move into Pathways early was a clear success story.

Interestingly, the ACOs that rebased on the traditional renewal schedule in 2019 or 2020 had unusually favorable experience in the 2016-2018 period, and then carried these performance levels forward once Pathways began.

EARLY RENEWALS IN 2022

In addition to evaluating the 2019/2020 contract renewals, we can also consider 2022 renewals. Here we focus on the 2019-2022 performance period, splitting ACOs into separate cohorts based on whether they were incumbent pre-Pathways and whether they joined Pathways in 2019 or 2020 or later.

FIGURE 12: GROSS SAVINGS RATES OF ACOS BY 2022 EARLY REBASING STATUS

ACOs Rebasing in 2022	Number	2019	2020	2021	2022
ACOs in MSSP Before Pathways					
ACOs Rebasing in 2019/2020 Only	197	3.6%	5.0%	4.3%	4.6%
ACOs Rebasing Early in 2019/2020 and 2022	4	1.5%	7.0%	7.5%	6.9%
ACOs Rebasing Normally in 2019/2020 and Early in 2022	7	6.1%	8.9%	7.1%	6.2%
ACOs Rebasing in 2022 Only	111	1.7%	2.5%	2.7%	2.4%
ACOs new in 2019/2020					
ACOs Rebasing in 2022	18	2.8%	5.3%	4.3%	6.2%
ACOs Not Rebasing in 2022	79	1.6%	3.6%	2.8%	3.3%
ACOs new in 2022	66				2.8%

[20] This cohort is restricted to ACOs that would have been required to join Pathways by 2021 (delayed to 2022) but rebased in 2019 or 2020. Additional ACOs that would have been required to join Pathways by 2020 may have rebased early in mid-2019; that cohort is excluded from this analysis.

We note two groups in particular: first, there were 11 pre-Pathways incumbent ACOs that joined Pathways in 2019 or 2020 (some early, some on the normal timeframe) and then elected to rebase in 2022. These ACOs did not improve their gross savings levels further in 2022; however, each of these ACOs moved from a Basic track (a mix of C, D, and E) to Enhanced. Because Enhanced features a max shared savings rate of 75%, while Basic has a max of 50%, and each of these ACOs had a positive gross savings rate in 2022, the net savings received by these ACOs collectively increased due to this decision, even if the gross savings levels collectively declined somewhat.

We also note the results from 2022 rebasing among ACOs new to MSSP in 2019 or 2020. Among these newer ACOs (which as noted above also include reentrants), 18 ACOs elected to rebase early in 2022, and as a group they improved their gross savings levels much more than other cohorts.

DOES IT MAKE SENSE TO RENEW EARLY?

Any ACO's decision on early renewal will hinge on many factors specific to the ACO, in particular its level of risk tolerance and its projections of the next few years as compared to recent performance. However, the results of the past few years at the very least suggest that ACOs should be consistently evaluating their performance and projections to determine if and when early rebasing might make sense for them; this is especially true given that the new MSSP contract period is now five years instead of three.

The ACOs that have gone through this evaluation process and determined that early rebasing was right for them have overall outperformed their peers by fairly substantial margins overall. This does not mean that rebasing is always appropriate for all MSSP ACOs, but it does suggest that there may be additional ACOs that could benefit from this option in the years to come. This may be particularly true for ACOs that are seeing adverse experience, as some of the largest improvements in performance after early rebasing have come from cohorts with average to below-average pre-rebasing performance levels, and those ACOs that are seeing especially favorable experience and may benefit from moving into a higher risk track to take advantage of higher shared savings ratios.

Overall MSSP results

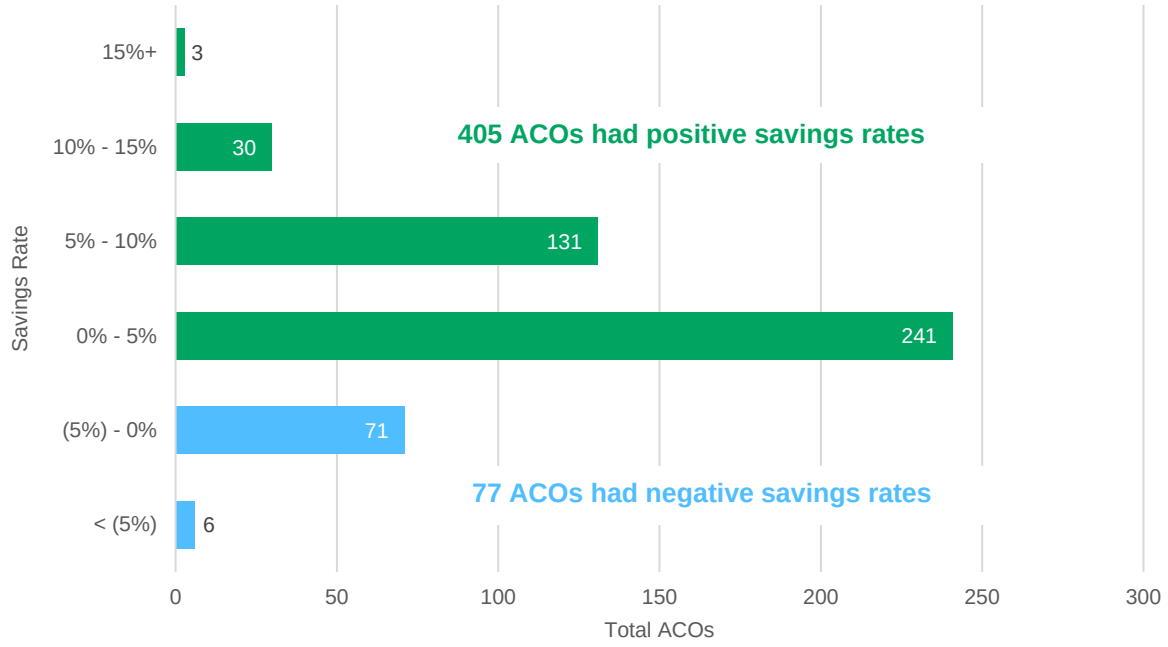
As noted earlier in this report, when we discussed the difference between gross and net savings, the report focuses primarily on gross savings amounts, as we believe they are the best ACO performance measure agnostic of risk track. Initially, we will discuss high-level data on ACO savings rates; subsequent sections will discuss observations and correlations around these savings rates.

In our savings rate exhibits, we primarily focus on 2022, the most recent full year of MSSP experience.

DISTRIBUTION OF ACO SAVINGS RATES BY YEAR

On average, ACOs have generated savings over time (compared to the benchmark), and 2022 is no exception. In 2022, the average savings rate across ACOs was 3.6%. This savings rate represents a composite across ACOs, with considerable variances by individual ACO. Figure 13 summarizes the number of ACOs within ranges of savings rates specific to 2022; note that, for this figure, negative savings are equivalent to gross losses.

FIGURE 13: 2022 GROSS SAVINGS RATE DISTRIBUTION

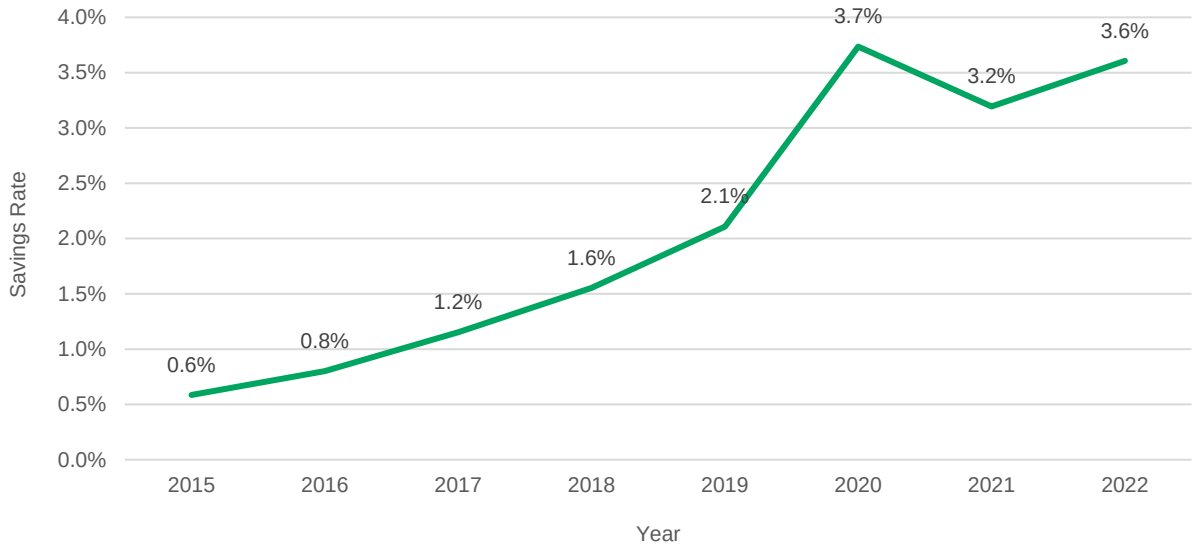


In 2022, 84% of all ACOs reported positive savings, and 34% had savings above 5%. These values represent a continued improvement against earlier years (with the exception of 2020, where savings were substantially impacted by COVID-19).

AVERAGE SAVINGS RATES BY YEAR

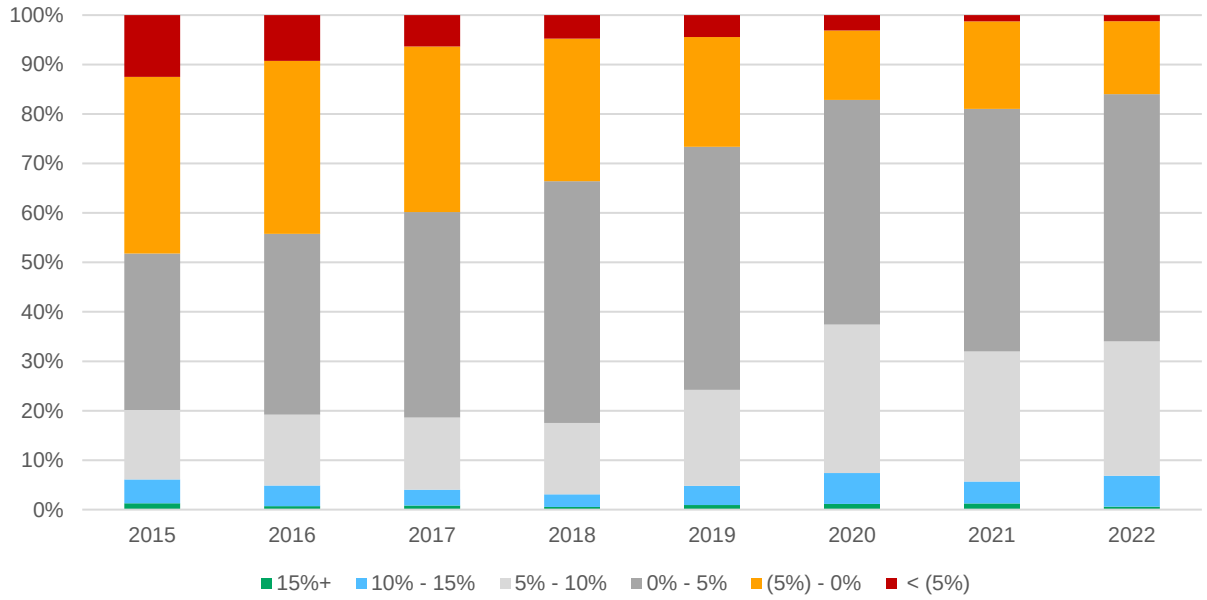
Savings rates for specific ACOs have varied between performance years, but the overall MSSP trend is that ACOs are generating increased savings over time. Figure 14 summarizes the average savings rates by year; while the 2020 savings rate may have been materially improved by COVID-19 impacts on claims, the longer-term pattern in savings has been relatively steady and positive, as illustrated by the 2021 and 2022 values roughly fitting the curve established through 2019 if we exclude 2020. As low-performing ACOs have exited the program, remaining ACOs have improved their abilities to manage care and expenditures, and Pathways to Success has become the new MSSP model for all ACOs, the average savings rate has increased.

FIGURE 14: AVERAGE GROSS SAVINGS RATE BY YEAR



Additionally, we observe a steadily decreasing share of ACOs with losses from 2015 onward, and an increasing share of ACOs with 5% or higher gains starting in 2019. Figure 15 illustrates these patterns.

FIGURE 15: AVERAGE GROSS SAVINGS RATE DISTRIBUTION BY YEAR



Observations on gross savings rates

In this section, we show the distribution of achieved savings rates based on various characteristics, such as size, revenues, risk scores, and quality scores. These exhibits illustrate the variability that exists in the ACO space.

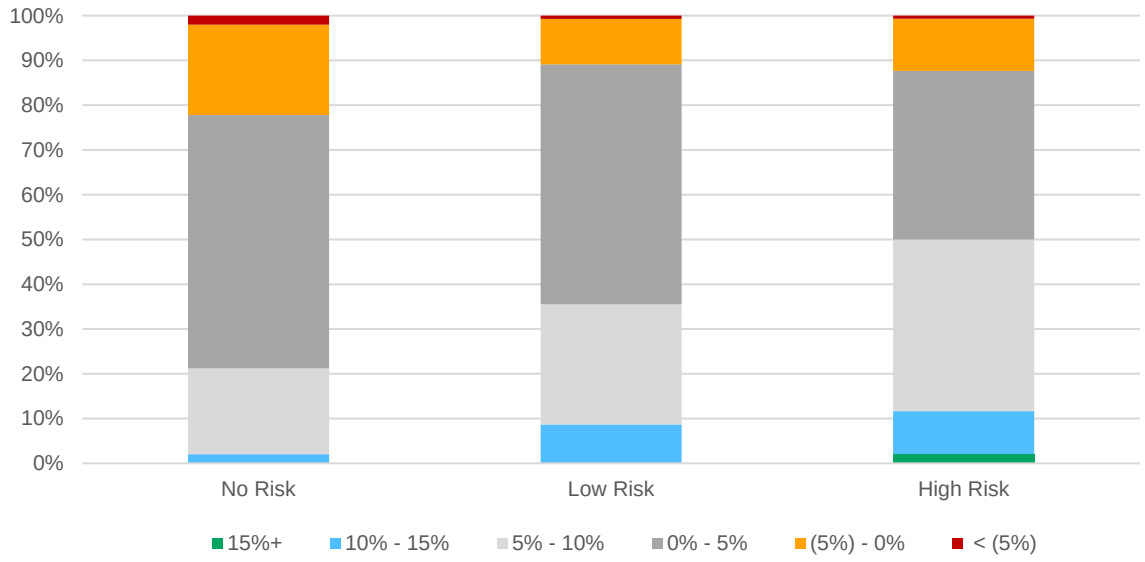
An earlier Milliman study performed statistical analyses on a number of plan characteristics, including factors outside the PUF files, against the 2019A PUF data.[21] This analysis can reasonably be compared to that study, and indeed a number of its conclusions are similar. We recommend that interested readers consider both analyses while developing a better understanding of the underlying drivers of ACO performance.

TRACK

As shown in Figures 1 through 6 above, there has been substantial shifting in the distribution of ACOs by track over time. By 2022 less than half remained in contracts without any downside risk. We therefore consider it important to examine the distribution of savings rates by risk levels.

In Figure 16, we show the distribution of savings rates for the same groupings of risk levels used in Figures 5 and 6 above (no risk, low risk, and high risk). This figure demonstrates a broad pattern of savings rates that are higher for ACOs taking on risk, as compared to the upside-only ACOs. We additionally observe a pattern of ACOs taking on higher levels of risk outperforming those taking on lower levels of risk. As discussed in the Pathways to Success section above, some of this may be due to self-selection, with higher-performing ACOs actively selecting higher-risk tracks.

FIGURE 16: GROSS SAVINGS RATE DISTRIBUTION BY MSSP RISK LEVEL FOR 2022



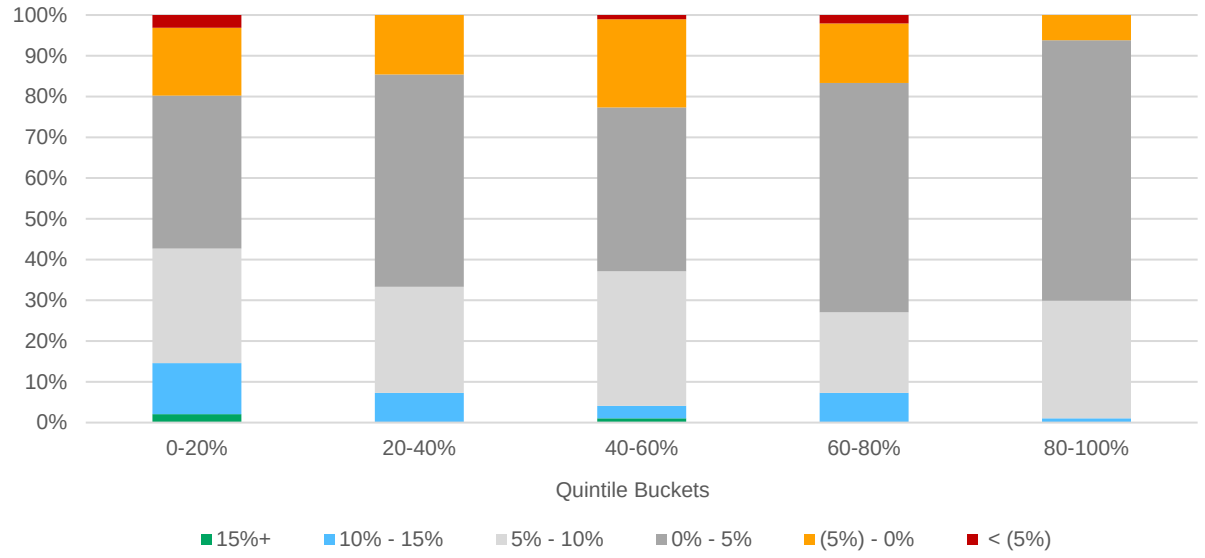
[21] Larson, A., Egan, M., Richards, R., & Gusland, C. (August 2021). What Predictive Analytics Can Tell Us About Key Drivers of MSSP Results: 2021 Update. Milliman White Paper. Retrieved March 28, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2021-articles/8-25-21-what-predictive-analytics-can-tell-us.ashx.

ACO SIZE

One possible characteristic associated with savings rate variation is ACO size, in terms of beneficiaries served. All else being equal, it is reasonable to expect random noise to have a relatively larger impact on savings rates for small ACOs while larger ACOs have more stable levels of savings.

As shown in Figure 17, actual savings rates for 2022 are broadly consistent with this theoretical expectation, with the largest gains and losses generally being associated with smaller ACOs (by beneficiary count), and relatively more average outcomes generally being associated with larger ACOs.

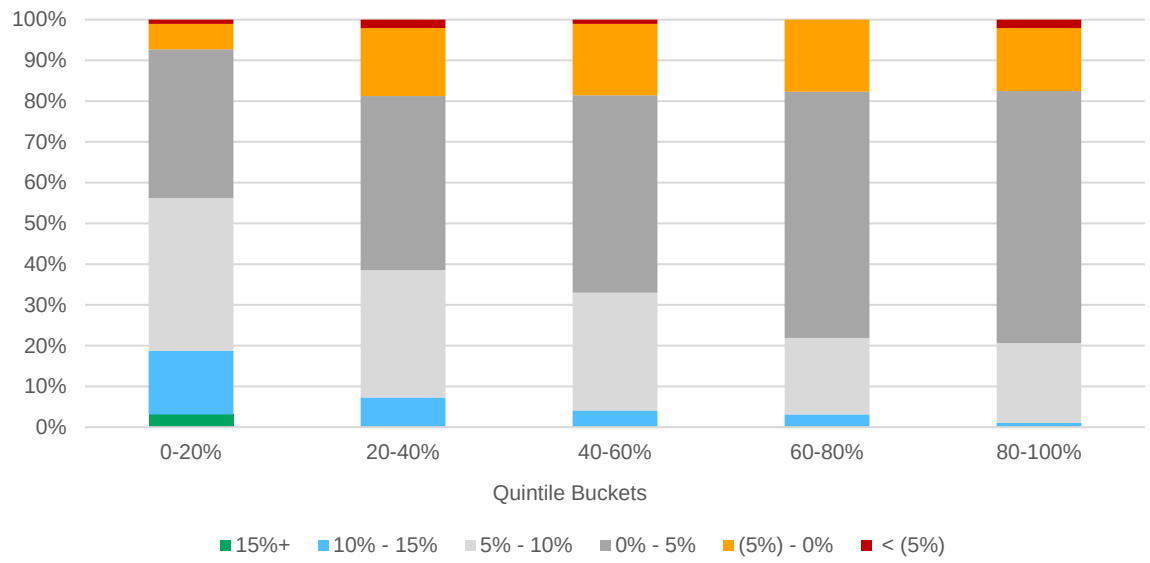
FIGURE 17: GROSS SAVINGS RATE DISTRIBUTION BY BENEFICIARY COUNT PERCENTILE



We also tracked the savings rates based on the number of providers associated with an ACO instead of the number of beneficiaries. We show these results below. As you can see in Figure 18, the two sets of graphs broadly parallel each other. Given that we would normally expect the largest ACOs to have more beneficiaries and more providers, and the smallest ACOs to have fewer beneficiaries and fewer providers, this is not surprising.

However, we note that the tables, while broadly similar, are not precisely parallel. For instance, we can see that the proportion of ACOs with savings rates of 5% or more (light gray, blue, and green sections) decreases in each step as the size of providers grows, while this is not the case in Figure 17 (by beneficiary count).

FIGURE 18: GROSS SAVINGS RATE DISTRIBUTION BY PROVIDER COUNT PERCENTILE

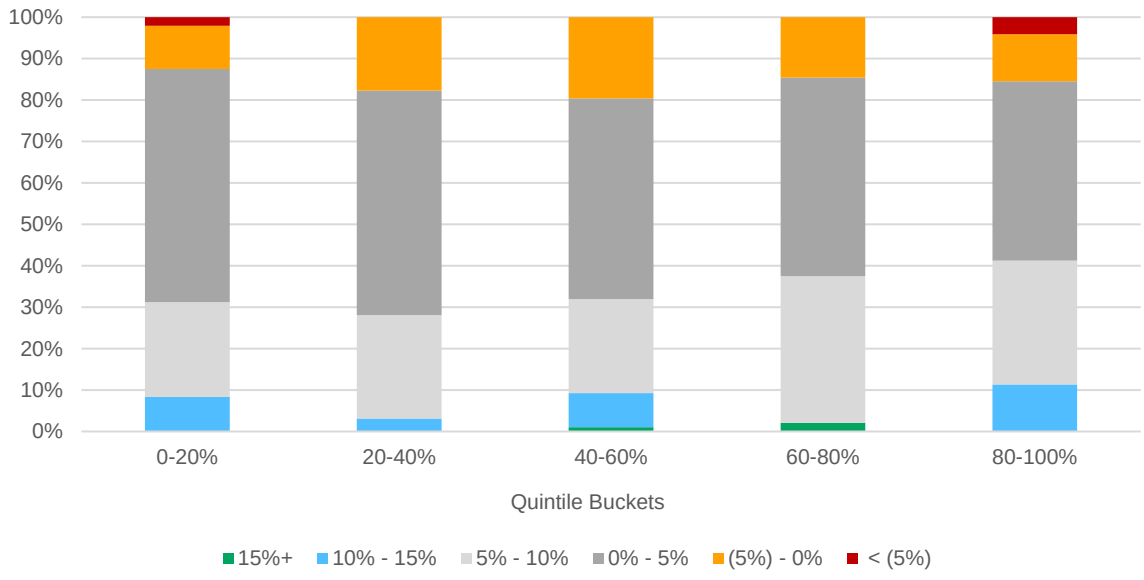


BENCHMARK RATES

ACOs across the country receive substantially different benchmark rates depending on area, mix of beneficiary types, and population risk score.

In Figure 19, we observe that the highest-benchmark ACOs have achieve a somewhat wider range of results than lower-benchmark ACOs; in particular, there was a higher percentage of ACOs with large gains for the ACOs with the highest 20% of benchmarks.[22]

FIGURE 19: GROSS SAVINGS RATE DISTRIBUTION BY BENCHMARK PERCENTILE



[22] The 80%-100% percentile range had the highest rate of 10%+ savings (combination of blue and green bars) and highest rate of 5%+ savings (combination of light gray, blue, and green bars).

RISK SCORES

Given that benchmark rates are, in part, a function of risk scores, we examined the population risk scores as well. Here, the PUFs provide normalized CMS Hierarchical Condition Category (CMS-HCC) risk scores and beneficiary counts separately by Medicare eligibility category:

- End-stage renal disease (ESRD)
- Disabled
- Aged, dual
- Aged, non-dual

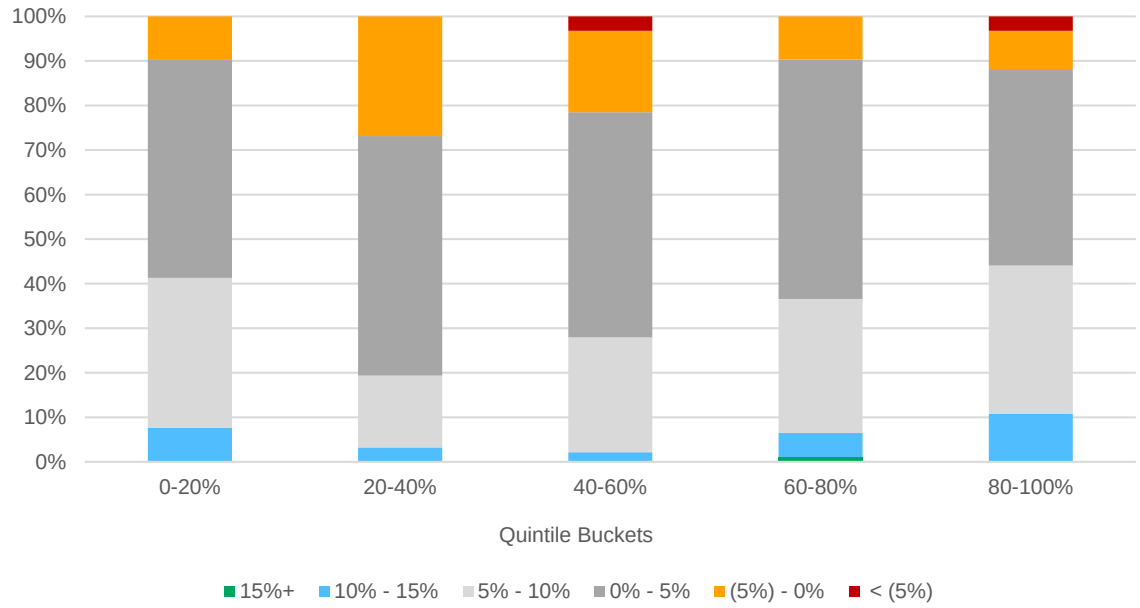
For the purposes of this calculation, we blended the risk scores across categories using beneficiary-weighted risk scores. Please note that a more precise calculation would factor in the impact of area as well as the baseline benchmark differences for the four categories.

Here we observe a substantial correlation between large achieved savings rates and higher population risk scores. Unlike the benchmark rates, however, there is no corresponding increase in the rate of ACOs with losses at higher risk scores. We also note a correlation between large achieved savings rates and particularly low population risk scores.

We take this as evidence that the relationship between risk scores and savings is more complicated than a simplistic model of high risk scores being driven by high coding levels, which then also drive savings. These results also argue against another simplistic model, where savings are disproportionally driven by a handful of ACOs focusing on high-cost diseases for selected population groups.

Instead, we observe a pattern more like a V shape; ACOs with the highest risk scores or the lowest risk scores tend to have greater savings, and the ACOs with middling risk scores tend to have lesser savings. Among other conclusions, these results suggest that risk score levels do not directly correlate with accurate diagnosis capture, and that low risk scores do not necessarily imply a lack of diagnosis capture either.

FIGURE 20: GROSS SAVINGS RATE DISTRIBUTION BY RISK SCORE PERCENTILE

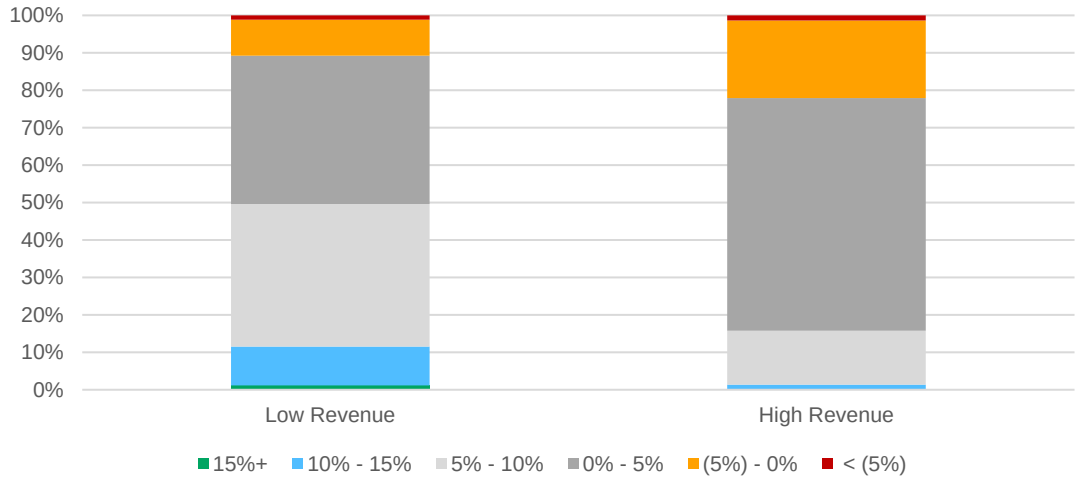


LOW/HIGH REVENUE

Per the December 21, 2018, Pathways to Success final rule and press release from CMS, an ACO is designated as low or high revenue based on the ratio of the revenue of its ACO participating providers, as compared to the total Medicare expenditures of the ACO's assigned beneficiaries; if the ratio is 35% or higher, the ACO is designated as "high revenue," and if it is under 35% it is designated as "low revenue."[23]

CMS further noted that "low-revenue ACOs (which are typically composed of physician practices and rural hospitals) outperform high-revenue ACOs (typically ACOs that include hospitals)." This may be at least partially driven by the competing interests of high-revenue ACOs to maintain revenue within their hospitals while at the same time reducing the total expenditures for their attributed lives. We have analyzed the PUF data split by low- versus high-revenue designations and have observed a similar pattern. Figure 21 shows the distribution of savings rates by low-revenue versus high-revenue ACOs; the low-revenue ACOs have substantially more ACOs with 5% to 10%, 10% to 15%, and 15%+ savings rates, and substantially fewer ACOs with negative savings rates.

FIGURE 21: GROSS SAVINGS RATE DISTRIBUTION BY LOW VS. HIGH REVENUE



INITIAL START DATE/DURATION

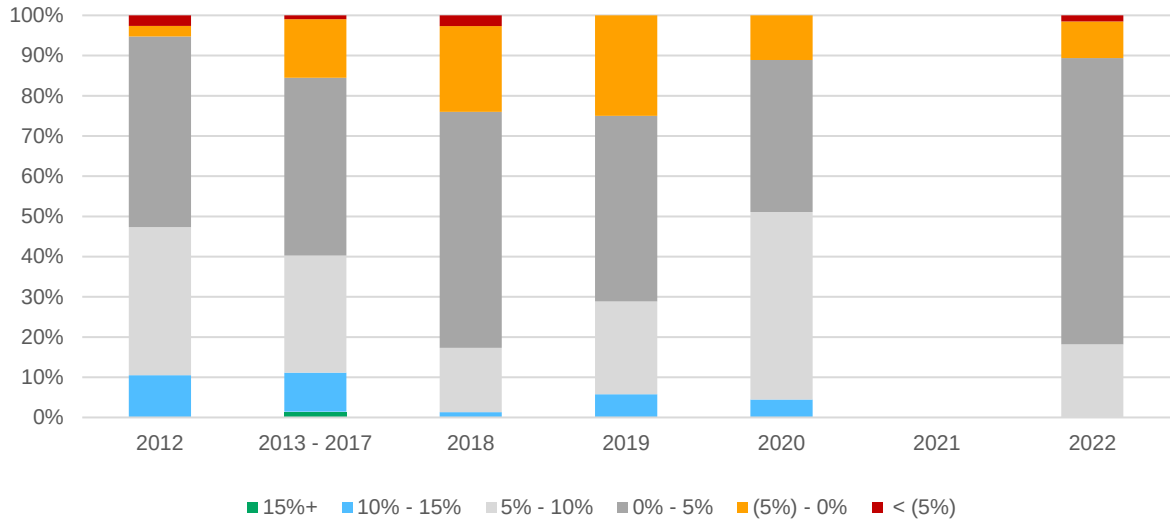
Another potentially relevant contributor to savings is duration of time in MSSP. It can take new ACOs some time to reach performance levels that would result in positive savings; additionally, for longer-term ACOs there may be some survivor bias, as the lowest-performing ACOs are likelier to have left the program.

In Figure 22, we tracked the savings rate distribution sorted by initial start date. The leftmost column is the 2012 start date, the rightmost three columns are the most recent start dates (current year, prior year, two years prior), and the second column from the left represents all other time periods. Note that no ACOs were allowed to begin their agreement period in 2021, hence the absence of 2021 in the figure.

In this chart, we can see that the longest-tenured ACOs (2012 start date) have done particularly well; however, ACOs with other start dates did not show as clear a relationship between start date and 2022 savings. In previous years, we had observed that the 2018 cohort had persistently lower savings than other cohorts during some performance years. This gap has reemerged in 2022. We will continue to monitor this cohort in future years as well.

[23] Centers for Medicare and Medicaid Services (December 21, 2018). Fact Sheet: Final Rule Creates Pathways to Success for the Medicare Shared Savings Program. Retrieved March 28, 2024, from https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program.

FIGURE 22: GROSS SAVINGS RATE DISTRIBUTION BY INITIAL START DATE



QUALITY

We also note that quality scores can impact net savings. As noted in CMS's documentation, the final (net) shared savings rate is the product of the quality score and the gross sharing rate up through performance year (PY) 2020.[24] Beginning in PY2021, CMS modified the rules such that ACOs share in the maximum shared savings rate available for their risk tracks if they meet minimum quality requirements (otherwise they are not eligible to share in any savings). For PY2023, CMS is planning to revise this rule further to shift to a sliding scale approach for ACOs that fall below the 30th or 40th percentile quality standard threshold.[25]

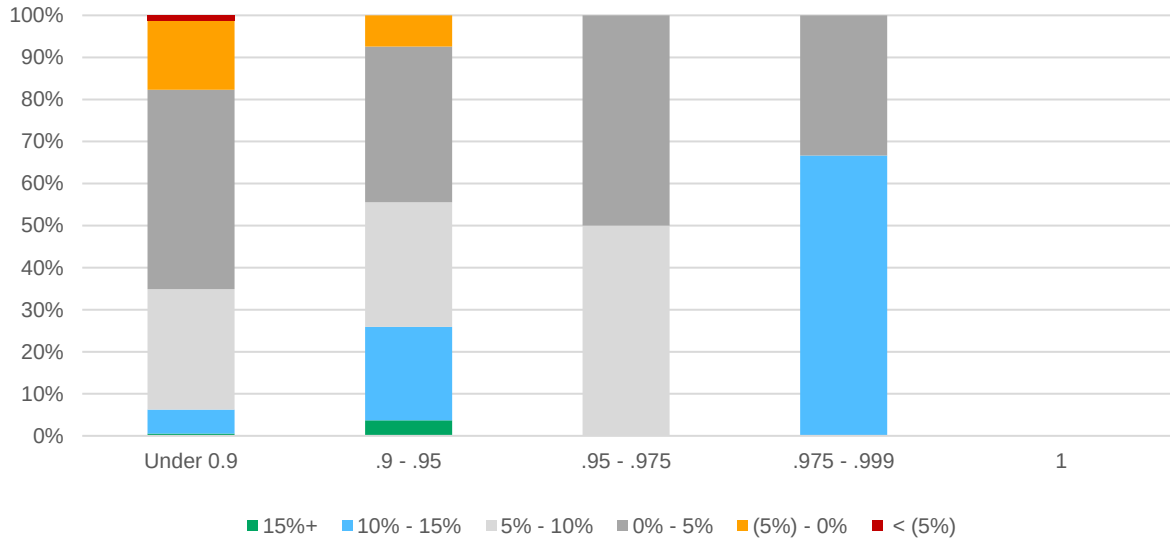
Beyond the relationship between quality scores and *net* savings, we considered it possible that there would be an additional association between quality scores and *gross* savings. We therefore tested the relationship between quality scores and gross savings rates, as shown in Figure 23.

While we have not historically observed a strong relationship between quality scores and achieved gross savings rates, the pattern for 2022 may suggest that a correlation could be emerging going forward. We will continue to observe this potential relationship in the coming years.

[24] Centers for Medicare and Medicaid Services (August 2020), Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology, op cit.

[25] Centers for Medicare and Medicaid Services. Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule – Medicare Shared Savings Program. Retrieved March 28, 2024, from https://edit.cms.gov/files/document/mssp-fact-sheet-cy-2023-pfs-final-rule.pdf.

FIGURE 23: GROSS SAVINGS RATE DISTRIBUTION BY QUALITY SCORE RANGE (EXCLUDING FIRST YEAR MSSPS)



Limitations and data reliance

The results contained in this report were compiled using data and information available in the CMS PUFs. This data was retrieved as of March 28, 2024, from CMS's database.

The information was relied upon as reported and without audit. We performed a limited review of the data for reasonableness and consistency. To the extent that the data reported contained material errors or omissions, the values contained within this report would likewise contain similar reporting errors.

This report is intended for informational purposes only. Milliman makes no representations or warranties regarding the contents of this report. Likewise, readers of this report are instructed that they are to place no reliance upon this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The views expressed in this research report are made by the authors and do not represent the opinions of Milliman, Inc. Other Milliman consultants may hold alternative views and reach different conclusions from those shown.

Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Matthew Smith and Brent Jensen are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Matthew Smith
matthew.smith@milliman.com

Brent Jensen
brent.jensen@milliman.com

Jacob Anderson
jacob.anderson@milliman.com

Korye Lockett
korye.lockett@milliman.com