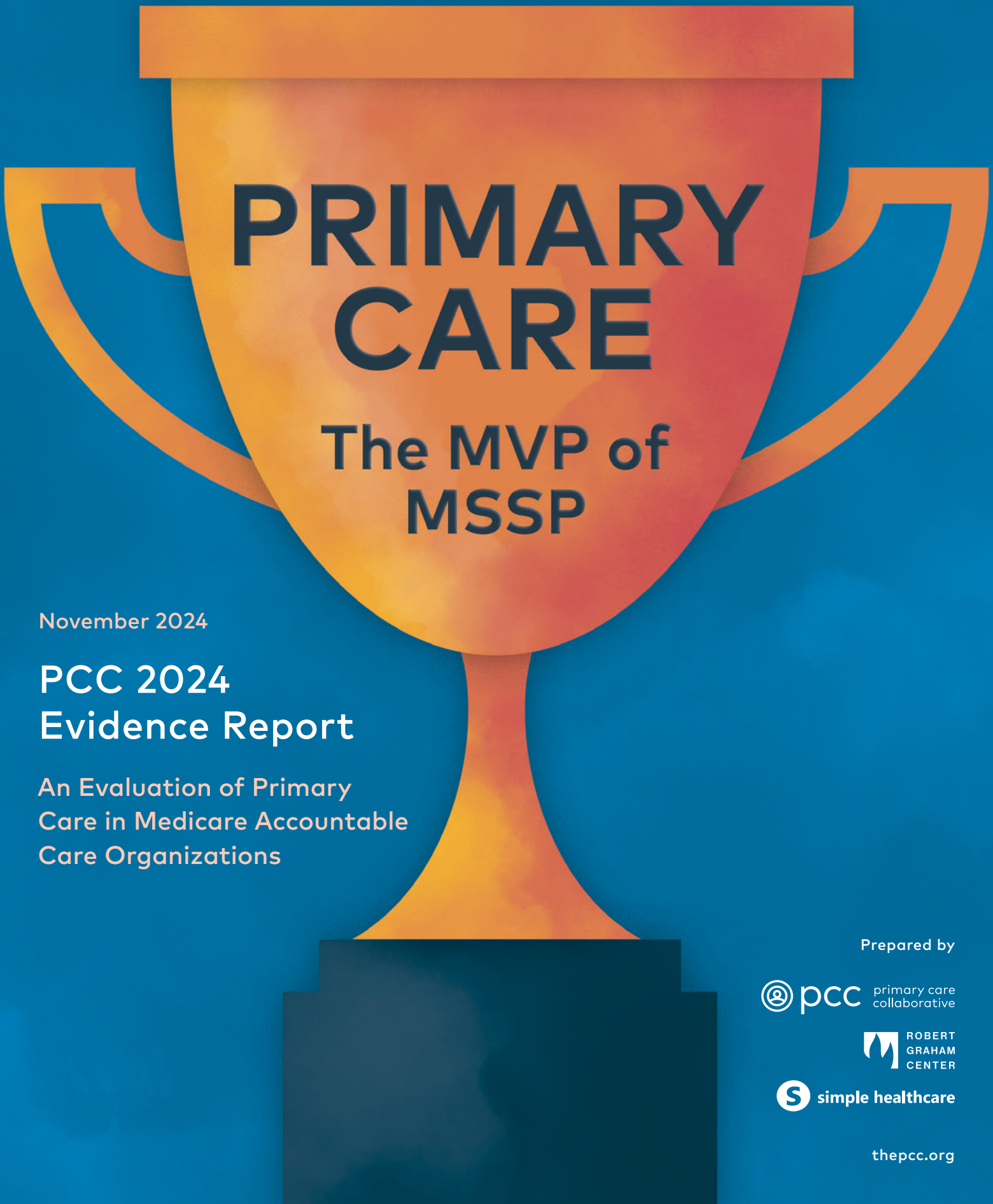

November 2024

PCC 2024 Evidence Report

An Evaluation of Primary Care in Medicare Accountable Care Organizations

Prepared by

pcc primary care collaborative

ROBERT GRAHAM CENTER

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Dear colleagues,

This spring, the Congressional Budget Office (CBO) released an issue brief highlighting the greater savings achieved by Medicare Accountable Care Organizations (ACOs) that are led by independent physician groups and those with a high proportion of primary care physicians.[1] This report was welcome news about the success of a value-based payment model—the Medicare Shared Savings Program (MSSP)—from the official budget scorekeeper for the U.S. Congress.

Additionally, the Centers for Medicare and Medicaid Services (CMS), in releasing MSSP 2022 results in January of this year, reported that low-revenue ACOs composed of 75 percent primary care clinicians or more saw net savings of more than twice as much as high-revenue ACOs.[2]

The Primary Care Collaborative's 2024 Evidence Report examines primary care centric ACOs, which we define as those with a high proportion of participating primary care physicians and evaluation and management visits by primary care. Using both quantitative and qualitative analyses, we seek to better understand what is contributing to their success, with the goal of informing both policymakers and innovators working to move our health care system from volume to value. PCC partnered with the Robert Graham Center and Simple Healthcare to produce this report.

As our report was in pre-production, CMS released the MSSP results for the 2023 program year, yielding $2.1 billion in shared savings, the largest in MSSP history.[3] While we were not able to incorporate the 2023 results in the 2017-2022 longitudinal analysis featured in this report, our analysis found that the 2023 MSSP results are consistent with the findings discussed here. CMS reported that MSSP ACO aggregate and average savings increased in 2023, with primary care-led ACOs outperforming other types of ACOs:

"ACOs led by primary care clinicians had significantly higher net per capita savings than ACOs with a smaller proportion of primary care clinicians. These results continue to underscore how important primary care is to the success of the Shared Savings Program."[4]

Our report is particularly relevant as policy leaders on Capitol Hill are coming together across the aisle and in conjunction with the executive branch to consider new primary care payment policies that would achieve better overall patient outcomes, enhanced equity and affordability, and lower costs.[5] The need for such action is urgent, as warning signs about our health care system's dismal performance mount, including placing last in a 2024 10-nation report card from the Commonwealth Fund, widening gaps in life expectancy between the United States and European nations and an expected premium increase of 8 percent for group insurers in 2025.[6–8]

While it will take a multifaceted approach to substantively improve the U.S. health care system, growing evidence suggests that the combination of robust and appropriately financed primary care—in models where incentives are aligned across the system—delivers results. Now, we must scale such models to reorient our system toward health and wellness.

Regards,

Ann Greiner
President and CEO
Primary Care Collaborative

Executive Summary

PCC's 2024 Evidence Report focuses on the role of primary care in Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP), Medicare's largest value-based payment model. The report examines a subset of MSSP ACOs that are primary care centric, as defined by two measures:

- 50 percent or more primary care physicians as a percentage of all physicians contracted by the ACO
- Top quintiles of ACOs with respect to primary care evaluation and management (E&M) visits as a percentage of all physician E&M visits, per 100 beneficiaries

Primary care centric MSSP ACOs were identified for examination because they have consistently and significantly outperformed other ACOs according to the Congressional Budget Office, yet have not grown in prevalence despite this successful track record.[1]

This report focuses on primary care physicians, as opposed to all primary care clinicians, because available datasets do not distinguish between nurse practitioners and physician associates in primary care versus specialty care. This study also explores how the performance of ACOs might be affected by serving beneficiaries of high economic and social need and whether the service locations of ACOs include such high-need beneficiaries. In addition to the quantitative analysis, the report includes three case studies of high-performing primary care centric ACOs.

ACO Background and Markers of Success

ACOs saw early rapid growth, a decline and a more recent plateau in traditional Medicare fee-for-service. In part, their early growth was due to their inclusion in the Affordable Care Act in 2010 as a voluntary payment and delivery innovation.

ACOs differ in terms of payer, organizational composition, sponsoring organization, governance and approach. What unites them is their commitment to population-level accountability, with the opportunity to receive shared savings payments for meeting or exceeding annual quality and cost targets. Today, ACOs engage practices and systems

that predominantly deliver care to patients covered by commercial health plans and Medicare. Nearly half of beneficiaries in traditional Medicare (13.7 million) are assigned to a practice within an ACO. In 2021, across all payers, more than 36 million Americans were attributed to an ACO.[9,10]

Consistent markers of MSSP ACO success include longer time in the program; being physician-led and independent of a hospital or health care system; having a larger proportion of primary care physicians; and leveraging the annual wellness visit to focus on prevention, chronic care management and care coordination.[11–15] In PCC's 2018 Evidence Report, we highlighted additional factors that lead to success of an ACO—leadership, culture, technology, and payer and incentive alignment—but more research is needed to understand the impact of primary care participation in ACOs.[16]

Summary of PCC Results

Two main data sources informed the report's quantitative analysis: Center for Medicare and Medicaid Services' MSSP Public Use Files and the social deprivation index (SDI), a composite measure constructed by the Robert Graham Center using demographic data from the American Community Survey. This dataset quantifies levels of economic and social disadvantage at the county level.

Key findings for the years from 2017 to 2022 include:

- MSSP ACOs in the highest quintiles of primary care centricity were consistently more likely to generate savings and generate savings above the median rate, as compared to ACOs with a lower measure of primary care centricity. (See Figure 4.)
- Primary care centric ACOs outperformed most other ACOs. Concurrently, the median level of shared savings of all MSSP ACOs increased modestly, from 1.1 percent to 3.4 percent.
- High primary care centric ACOs generated 2.4 times the savings as low primary care centric ACOs between 2017–2022. (See Table 1 in sidebar.)
- By two different measures examined, MSSP ACOs did not appear to achieve these savings by targeting beneficiaries that have fewer social and economic vulnerabilities, although more research is needed at a smaller geographic level to confirm this encouraging finding.

> **"ACOs led by primary care clinicians had significantly higher net per capita savings than ACOs with a smaller proportion of primary care clinicians. These results continue to underscore how important primary care is to the success of the Shared Savings Program."[4]**
>
> Centers for Medicare and Medicaid Services, October 2024

Table 1 highlights the consistency of relatively high performance of primary care centric ACOs over six years. Over the period 2017–2022, high primary care centric ACOs generated 2.4 times the savings as low primary care centric ACOs.

TABLE 1

The Annual Savings Average of ACOs Based on Percentage of Participating Primary Care Physicians (PCPs), High (Greater Than 50 Percent) Compared to Low (Less Than 50 Percent)

Year	ACOs with less than 50 percent PCPs, percent savings	ACOs with greater than 50 percent PCPs, percent savings	Ratio of high percent PCP-to-low percent PCP savings
2017	0.6 %	2.4%	4
2018	0.8%	2.7%	3.4
2019	1.4%	4.5%	3.2
2019.5	2.0%	4.4%	2.2
2020	3.0%	5.5%	1.8
2021	2.4%	5.3%	2.2
2022	2.5%	5.9%	2.4
Avg	**1.8%**	**4.3%**	**2.4**

- Further, our analysis of the 2022 CMS data identified ACO "bright spots": 25 primary care centric MSSP ACOs that achieved the highest savings, representing about 5 percent of all participating MSSP ACOs in 2022. See the list on page 27.

As our report was in pre-publication, CMS released the 2023 MSSP results. While we were unable to include the 2023 results in our report in detail, our analysis did find found that the high-level findings described by CMS are consistent with our findings with respect to primary care centric ACOs.

From the list of Bright Spots identified above, three ACOs were selected as case studies for this report to learn more about the factors that contributed to their success, including:

- Colorado-based Community Health Provider Alliance (10.4 percent savings rate in 2022)
- Louisiana-based LA MSSP Enhanced ACO (15 percent savings rate in 2022)
- One Health Nebraska (9.7 percent savings rate in 2022).

These ACOs serve urban and rural geographic areas, beneficiaries with both low and high social needs, contract with varied types of practices (including Federally Qualified Health Centers) and have differences in approach with respect to governance, data and analytics, and other strategies.

Cross-cutting themes across these three ACOs include:

- They provide timely, actionable clinical and performance data to practices, including community health centers, such as care gaps to be addressed in clinical encounters. Different data sources are integrated to inform decision-making and to optimize performance.
- They establish multiple methods for practices to align processes by sharing results to improve performance, both clinical and financial. The learning community or learning labs help to lift all boats so the ACO is successful overall.
- Their practices work independently, making their own decisions about resources, workflow and care delivery design, to achieve results that benefit patients, clinicians, practices and the ACO.
- They initially keep the interventions and data collection simple and do not take on too many focus areas simultaneously. Then, they build out more interventions as the practices demonstrate success.
- They support local creativity and a bottom-up approach to achieving quality and cost-savings benchmarks, while keeping the centralized functions lean.

Options to Grow More Primary Care Centric ACOs

With the recent introduction of ACO Primary Care Flex, CMS increasingly recognizes the importance of strengthening primary care in the MSSP ACO program. This voluntary model is focused on driving more investment through hybrid primary care payment, an upfront monthly payment plus fee-for-service payments.[17]

Leaders should consider an array of additional policies to quickly foster the growth of more primary care centric MSSP ACOs, arguably the most successful value-based care model at scale, given that they are flatlining. Policy options for consideration fall into three categories: better research, data and guidance; enhancements for beneficiaries; and enhancements for primary care centric ACOs. The policy ideas in each category are detailed below.

Better Research, Data and Guidance

- Enhance workforce data collection and reporting with minimal burden, specifically for nurse practitioners and physician associates practicing in primary care
- Replace the low-revenue versus high-revenue MSSP ACO distinction with a new composite measure of primary care centricity—e.g., percentage of spending on primary care services, percentage of primary care clinicians, percentage of E&M visits delivered by primary care clinicians and percentage of spending on behavioral health services
- Provide a better roadmap for practices and ACOs considering joining or staying in various accountable care models

MSSP Enhancements for Patients

- Consider waiving Part B cost-sharing requirements for beneficiaries who obtain care from their chosen source of primary care within the MSSP ACO
- Incent more comprehensive primary care in the MSSP, starting with behavioral health integration

MSSP Enhancements for Primary Care Centric ACOs

- Create a new pathway within the MSSP that allows for primary care capitation, providing new and existing ACOs an opportunity to take on more risk and potentially more reward, beginning with primary care centric ACOs
- Consider increasing the shared savings rate for primary care centric ACOs, along with allowing more regulatory flexibilities as incentives to attract more such organizations
- Direct additional incentives for participation in Medicare advanced payment models, or APM Bonus, to primary care practices participating in ACOs
- Consider providing more support to primary care centric ACOs from CMS
- Review MSSP ACO governance structures to assure that primary care is well represented

The options above may attract more primary care-led ACOs to join or expand within the MSSP and provide the kind of team-based comprehensive care that improves health, reduces inequities and curbs costs by shrinking unnecessary specialty and hospital visits.

However, there are fewer independent primary care practices that may be able to respond to the proposed more favorable policy environment. Approximately 20 percent of physicians are independent of hospitals, insurance companies or venture-backed private equity organizations.[18] Consequently, it is incumbent on policymakers to consider what changes need to be put in place to better align hospital and hospital-system incentives with those incentives facing independent primary care practices and primary care centric ACOs.

When all practices, clinics and clinicians in the system are significantly incented to achieve gains in population health, affordability, equity and cost reduction, there will be momentum to shift the U.S. health care system to health and wellness. There is an urgent need to do so.

Introduction

The United States spends nearly 18 percent of total gross domestic product on health care, more than twice that of similar high-income countries. The U.S. payment model—predominantly fee-for-service—incentivizes overtesting, overtreatment, fragmentation and rapid patient visits to increase productivity and revenue. The current health care reimbursement system has failed to adequately compensate primary care teams for continuity, comprehensiveness, coordination and access for patients while encouraging high-cost care. Additionally, despite having the highest spending on health care among peer nations, the United States has not demonstrated improved health outcomes or longer life expectancy. Rather, there continue to be significant racial and socioeconomic health disparities and a life expectancy five years below European counterparts.

Many innovative payment and delivery models have been proposed by U.S. payers and government agencies to improve health outcomes for individuals and communities, improve longitudinal care and promote financial health care sustainability. Some incent the foundational use of primary care. Accountable Care Organizations offer one model to achieve these outcomes.

Accountable Care Organizations (ACOs) have created a novel avenue of accountability for patient outcomes across health care systems, hospitals, practices and clinicians. In this report, we define an ACO as a group of clinicians, practices and/or hospitals that take on financial risk and accountability for predetermined outcomes of a population. Typically, ACOs take on risk of financial loss with a proportional opportunity to share in financial savings.[19–22] Success is measured by a set of quality metrics (four domains, approximately 55 measures) and cost measures. ACOs are required to meet quality benchmarks before they can be rewarded for cost savings. Primary care is primely positioned to contribute to ACO shared savings by implementing preventive services and reducing downstream spending.

ACOs, first conceived in 2006, achieved greater prominence when they were included in the 2010 Affordable Care Act, with the goal of reducing costs while improving the quality of care. ACOs were also well positioned to reduce potential overuse in traditional Medicare.[19] At the inception of ACOs, organizations were intended to be clinician-led with a strong primary care foundation.[19–22] There are

multiple invested parties in ACOs: clinicians, clinics, hospitals, payers (mainly Medicare), value-enablers (such as Aledade) and patients. While ACOs may have been founded on the principle of strong primary care, the health community has yet to parsimoniously define the characteristics of a primary care centric ACO. Studies have evaluated the contributions of primary care to ACOs, physician leadership in ACOs and health outcomes of ACOs with a strong foundation of primary care. Yet no single measure defines a primary care centric ACO.

This analysis explores a functional definition of primary care-led ACOs through background research and analysis. From the existing literature, a taxonomy of ACOs will be discussed and attributes of ACOs associated with primary care engagement will be explored. Analytically, this report will establish a threshold of primary care participation that meaningfully ensures that communities have access to a primary care clinician in an ACO. Within the primary care centric ACOs, this report will evaluate quality metrics, shared savings and community accountability. To more fully understand the functionality, implementation and shared principles among ACO membership, this report also will provide qualitative context from three high-functioning primary care-led ACOs based on extensive interviews with their leadership and physicians.

ACO Taxonomy: A Noninclusive List of the Types of ACOs

Medicare Shared Savings Program (MSSP)

The MSSP is a permanent ACO defined by CMS that supports a fee-for-service structure for payment within the ACO participants. There are two tracks that participants can join based on how much risk the organization takes on (basic or enhanced).

Medicare ACO Realizing Equity, Access, and Community Health (REACH) Program

The Medicare ACO REACH program began in 2023 and aimed to support ACOs that reduced health inequities among their beneficiaries. Participating organizations may participate in professional risk sharing (50 percent savings or losses with capitated primary care payment) or global risk sharing (100 percent shared savings or losses with either a primary care capitation or total care capitation).

ACO Primary Care Flex Model

The optional ACO Primary Care Flex model, slated to begin in January 2025, focuses on ACOs that generate low revenue within the fee-for-service, or MSSP, reimbursement schema. This model will provide an advanced shared savings payment to organizations in addition to monthly prospective payments with the aim of improving medical and social needs. It incorporates the principles of primary care to improve population health, as described in the 2021 National Academies of Sciences, Engineering, and Medicine Report on Implementing High-quality Primary Care.[23]

ACO Investment Model (Retired in 2020)

This model was for MSSP ACOs in rural and underserved areas that received prepaid savings based on anticipated shared savings for their region. This model aimed to financially incentivize the expansion of ACOs to more remote areas, with fewer ACOs that may benefit from upfront financial gains. This model resulted in an increased number of ACOs in areas with more health care needs and lower access to care. There was an estimated reduction of $381 million in health care spending and decreased hospitalizations, Emergency Department visits and days in skilled nursing facilities for beneficiaries.[24]

Next Generation ACO Model (Retired in 2024)

Experienced ACOs were eligible to participate in the Next Generation model. The goal of this model was to increase coordination of care and population health. Practices assumed a higher risk and reward than in the traditional MSSP model. The model resulted in reduced gross spending but no change in net Medicare Part A and B spending.[25] The largest decrease in spending for Next Generation ACOs was in physician practice ACOs.[26]

Background

Brief History of ACO Formation

The Affordable Care Act laid the foundation for population-level accountability, including ACOs in the Medicare program, and began to set the stage for improvements in access, quality and cost in the health care setting. The "Pioneer" ACO model began with 32 organizations in 2012 and ended with nine in 2016. The vast majority of Pioneer ACOs generated savings during their final years in the program, suggesting the importance of time in the program, as well as experience with and knowledge of quality measurement and reporting.

The initial practices and systems that enrolled in MSSP ACOs were geographically varied and present across the United States. In 2012, near the start of ACO incorporation, 55 percent of the U.S. population lived in an area with an MSSP ACO.[27] The characteristics of the areas associated with ACO formation included low poverty, preexisting managed care organizations, fewer physician groups, fewer primary care groups and high cost of care.[27] It is likely that these geographic and population characteristics were ripe for ACO formation, as the systems had experience with novel payment systems, had room for financial gain and the patients served had lower social complexity that would be less costly to address.

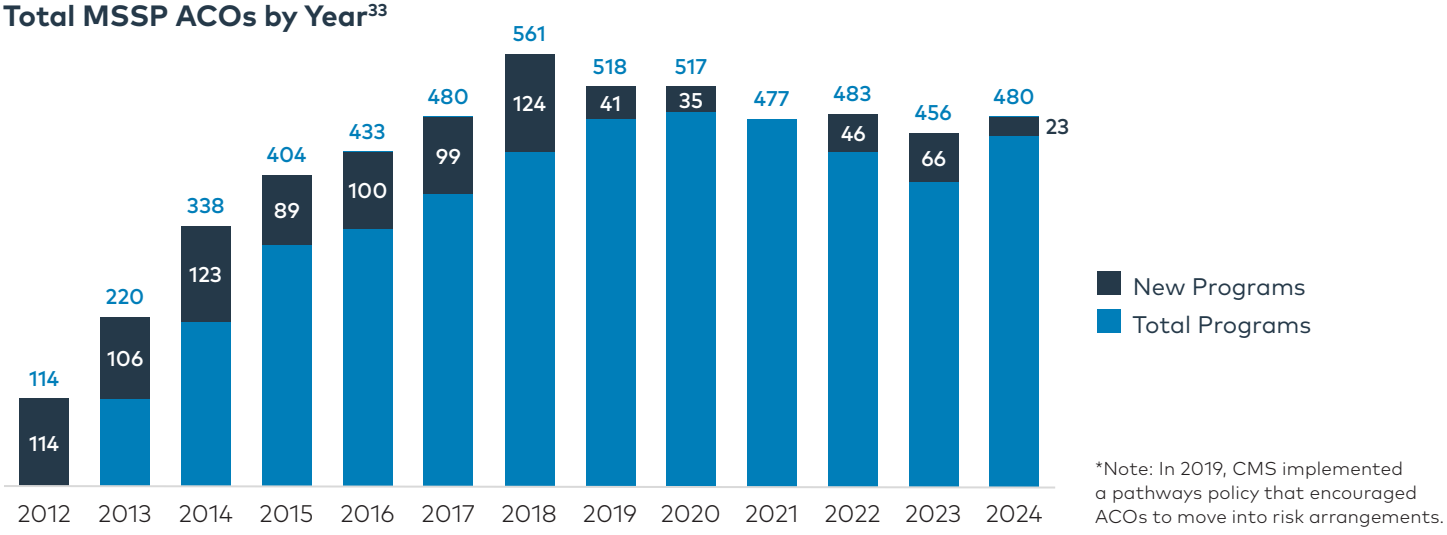
The geographic variability of ACOs has improved over the past 12 years. However, there also may be a "nonrandom exit" of clinicians from ACOs: Between 2008–2014, clinicians with the highest spending had a higher probability of exiting an ACO, thereby reducing cost and improving savings for the ACO.[28]

Initially, ACOs were largely governed by physicians and were physician-led (percent of clinicians participating): 51 percent of ACOs had physician leadership and 78 percent of ACO governing boards were comprised of a majority of physicians.[29]

In 2014, the 333 MSSP ACOs in the United States generated $411 million in net savings.[30] By 2024, there were 480 MSSP ACOs that cared for 10.8 million individuals living in the United States.[31] (See Figure 1.) And in 2023, MSSP ACOs generated $2.1 Billion in savings.

FIGURE 1

Total MSSP ACOs by Year[33]



*Note: In 2019, CMS implemented a pathways policy that encouraged ACOs to move into risk arrangements.

What Are the Requirements of Medicare MSSP ACOs?[32]

- Each ACO must have a sufficient number of primary care clinicians to have a minimum of 5,000 Medicare beneficiaries.
- ACOs must participate in the MSSP for no fewer than five years (as of 2019).
- ACOs must establish a structure for reporting quality and cost:
  - Providing and maintaining a public reporting webpage on the organization and performance of the ACO
  - Reporting the MIPS promoting interoperability performance category measures (beginning in 2025)
- ACOs must have a process to promote evidence-based medicine, patient engagement and coordinated care.
- ACOs cannot participate in other cost-savings initiatives but can participate in other innovation models such as bundled payments for care improvement or comprehensive primary care plus.

What Types of Organizations Can Become ACOs?

- Physicians
- Hospitals
- Networks of individual practices, including Federally Qualified Health Centers and Community Health Centers
- Joint ventures between hospitals and physicians
- Medicare providers such as imaging centers and surgical centers
- Independent Practice Associations, which may form the basis of a physician-sponsored ACO

What About Commercial ACOs?

Commercial ACOs are similar to their Medicare counterparts. They rely on quality reporting, benchmarks, patient complexity and costs to identify shared savings. The level of risk and possible shared savings varies based on payer.

What Makes an ACO Successful?

Most ACOs are not successful in their first three years of formation; it is not uncommon for ACOs to have slight losses at their inception due to changing focus of the practices.[34]

In PCC's 2018 primary care evidence report, "Advanced Primary Care: A Key Contributor to Successful ACOs," we identified six factors that were associated with successful ACOs.[16] Specifically, literature at that time and expert consensus showed that leadership and culture, prior experience, health information technology, care management strategies, organizational and environmental factors, and incentive and payer alignment were associated with continuation as an ACO.[16] Several other factors have been found to be positively correlated to high financial performance. Since ACOs were established, there has been an increase in the percentage of physician-led ACOs, as compared to hospital-led ACOs: In 2018, 45 percent of all ACOs were led by physicians, 25 percent led by hospitals, and 30 percent jointly led by hospitals and physicians.[35] In 2010, by contrast, only 22 percent of ACOs were physician-led, while 63 percent were jointly led.

Physician-led ACOs demonstrate financial performance. Over time as an ACO, savings continue to increase and quality continues to improve.[36] Early in the ACO evolution, health care spending was reduced in ACOs—and most improved for independent primary care groups, as compared to hospital-integrated systems.[13] Longer participation in an ACO results in significantly greater spending reductions: For physician-led ACOs that had been enrolled in MSSP for three years, there was a decrease in spending of $474 per patient, but there was only a reduced spend of $156 per patient for those that had been in MSSP for one year.[13] This is compared to only a modest decrease of $169 per patient in hospital-led ACOs after three years (and an $88 increase after 1 year).

Multiple studies demonstrate the positive impact of a high proportion of primary care clinicians in an ACO.[38,39] In a 2017 analysis, there was a positive relationship between the proportion of primary care physicians in an MSSP ACO, physicians in governance positions and leadership, and a larger financial benchmark with shared savings.[39] Higher levels of physician involvement in an ACO's board has also been associated with improved patient outcomes (such as reduced hospital admissions).[40]

Two-Sided Risk

The second "track" of the MSSP program is two-sided risk, indicating that the ACO may either benefit from shared savings or lose money if spending is higher than regional benchmarks. In 2019, CMS implemented the Pathway Program that required two-sided risk. Prior to that program, however, ACOs could voluntarily enter into a two-sided risk contract, which offered increased financial opportunities if shared savings occurred. ACOs were more likely to enter into this track if they were large, affiliated with supporting organizations (e.g., Aledade Health) and had higher performance. Rural ACOs were less likely to enter the two-sided risk track.[37]

Not only is the structure of primary care involvement valuable, but patient visits to primary care improve success as well. Patients seen more frequently in-network with primary care clinicians have higher-quality care, as compared to those seen out-of-network; this is specifically true for patients of racial and ethnic minorities.[41] Experience with ACO metrics has been associated with improved savings. The longer time an ACO spends in the program, the higher the likelihood that the ACO will generate shared savings.[39]

How Financially Advantageous Are Primary Care-Led ACOs?

A central goal of ACOs is to improve quality while reducing health care costs and spending below a preset benchmark. This section will provide an evaluation of the literature on the financial impact of primary care-led ACOs and mechanisms for financial success.

Approximately 44 percent of patients seen in primary care are seen at a practice that participates in an ACO.[42] Between 2016 and 2020, there were between 432 and 548 MSSP ACOs (2020 n = 513). Forty-five percent of ACOs were physician-led. The total number of beneficiaries served ranged from 7.9 million to 10.6 million, and the total shared savings ranged from $691 million to $2.3 billion.[38]

Shared Savings and Benchmarks

For practices to be financially profitable in an ACO, they must meet benchmarks to receive shared savings. But what do these terms mean? A benchmark is a target for spending or quality that the organization must meet to qualify for shared savings. The target must be met by the patients attributed to the organization. Each ACO contracts with clinics regarding their benchmark and savings percent.

One example of a quality benchmark is blood pressure control. The benchmark for blood pressure control may be 80 percent of attributed patients with a blood pressure of less than 140/80 mmHg. Meanwhile, spending benchmarks typically use regional comparisons for relative spending or cost savings.

In general, ACOs with more experience (age) and those that assume two-sided risk have improved savings. ACOs in which beneficiaries have at least one primary care physician visit per year improve savings.[38] ACOs with the largest proportion of primary care clinicians have the greatest savings.[1] Patients attributed to small practices (those with fewer than 15 physicians) in ACOs had an average decrease of $269 more per beneficiary per year than large practice ACOs.[43] These small practices were commonly PCP-only practices. Overall, ACOs led by physicians have greater savings than those led by hospitals.[1]

Wellness Visits and Practice Focus Areas Associated with Success

An important lever for financial success is the use of annual wellness visits. Annual wellness visits are available to Medicare beneficiaries upon entry to the program, "Welcome to Medicare" visit and annually after their initial year of enrollment. The goal of the annual wellness visit is prescribed: There is a required checklist of items reviewed with each individual regarding their independence and daily activities. The physical exam is limited to height, weight and blood pressure, per the United States Preventive Services Task Force recommendations

for physical exam in asymptomatic adults older than 65. The annual wellness visit generates conversation about functional status and results in a personalized prevention plan. The visit is free for patients, and the reimbursement rate for practices is approximately $117 to $170 per beneficiary. Additionally, annual wellness visits provide attribution of a patient to a practice.

The use of annual wellness visits has been associated with reduced total spend per beneficiary in ACOs. A 2019 analysis demonstrated that patients' first-time annual wellness visits were associated with a 5.7 percent reduction in costs in the period after the visit.[42] In patients with more chronic comorbidities, savings increase. Annual wellness visit completion is also associated with improved clinical quality metrics (e.g., cancer screening, fall risk screening).

Improved health outcomes have also been achieved when ACOs place focus on specific areas. These may lead to financial success. ACOs may place priorities on preventive service completion, patient satisfaction, hierarchal condition categories (HCC) coding, chronic care management, data maintenance and use and feedback from financial performance to improve practice strategies. Preventive health, specifically addressed during the annual wellness visit, is necessary to prevent late-stage disease and act early when disease or negative health behaviors arise. Specifically, preventive measures that are shared by Medicare and other payers as common metrics have been targeted for improvement (depression screening, statin use for cardiovascular disease, blood pressure control). ACOs that actively update and engage patients in preventive screenings decrease patient morbidity and mortality, improve attribution and improve patient experience.[44] HCC coding optimization promotes the use of the most specific codes for a patient's comorbidity thus allowing the ACO to target vulnerable patients for more frequent primary care visits.[45] These touch points may reduce unnecessary ED visits, hospitalizations and unnecessary medication use. Coordination of care is essential to optimize medication adherence, treatment plans and promote equitable access to the system.[45]

Integration and Financial Impact of ACOs

ACOs may include a group of professionals in a practice, networks of individual practices, partnerships between hospitals and ACO professionals, hospitals that employ ACO professionals, critical access hospitals, Federally Qualified Health Centers, rural health centers and teaching centers. Outpatient surgical centers and hospital systems may participate in an ACO in addition to outpatient or ambulatory care facilities.

Integration of an ACO has an impact on its financial and quality metrics. A 2021 study of Massachusetts evaluated the level of integration and per-member spend.[46] The study's authors defined integration as the proportion of primary care providers who billed as part of a hospital outpatient department (as compared to those billing in an office setting not affiliated with a hospital, as reimbursement differs based on setting). This analysis found that ACOs with more integration with hospital systems had a higher spend per member per quarter ($1,179 for high integration versus $1,075 for low integration) and had a higher spend on inpatient services. Quality was equivalent regardless of integration level. In some instances, more highly integrated ACOs are in more vulnerable and higher-need areas, which may account for some increased spend, yet they also tend to have lower proportion of primary care providers and less physician leadership.

Quantitative Analysis of Primary Care Centricity of MSSP ACOs

A longitudinal quantitative analysis of MSSP ACOs was performed. The focus of the analysis is on the role of primary care in the performance of ACOs participating in the MSSP. Specifically, the analysis explores whether ACOs that deliver more primary care services per beneficiary and that are composed of more primary care clinicians (as a percent of all clinicians) are more likely to generate savings and more savings between 2017 and 2022. The analysis also examines whether ACOs serve geographic areas with residents of higher economic and social needs and whether this affects ACO performance. Early MSSP research suggested ACOs were not forming in low-income geographies.[27,47]

Previous research examining 2020 and 2021 data suggests that performance of ACOs participating in the MSSP is positively correlated with their share of primary care physicians and primary care services provided to beneficiaries.[14] Other analyses that look more broadly at the performance of physician-led ACOs in the MSSP find they have outperformed hospital-led ACOs on average over the history of the MSSP to date. The Congressional Budget Office highlighted these studies in an April 2024 report.[1]

Due to data limitations, this analysis is focused exclusively on primary care physicians and does not include other primary care clinicians. In contrast to physicians, the specialty of nurse practitioners and physician associates participating in ACOs is not captured and reported in the MSSP Public Use Files used for the analysis.

The analysis does not examine variation in quality performance as defined by the quality metrics used by the MSSP. Instead, the case studies and related interviews were used to gain insight into the role of quality in ACO outcomes. Variation in the composite quality score across participating MSSP ACOs is not as wide as the variation among ACOs in gross savings, and nearly all ACOs have met the quality threshold for eligibility for shared savings since 2021. CMS has also noted that ACOs participating in the MSSP outperform groups of clinicians not in the MSSP on the MSSP quality metrics.[2,48]

Data

The analysis includes six years of data (2017–2022) from the Centers for Medicare and Medicaid Services MSSP Public Use Files. The CMS Public Use Files, which can be found here, include historical information on ACOs and their participating provider and clinician organizations, cost benchmarks, utilization, the number of attributed beneficiaries by county, spending and performance data by year. The files also include information on the counties of attributed beneficiaries, which can be used to create a geographical service area for each ACO annually. In addition, information on participating providers was connected based on advanced alternative payment model participation to serve as a sensitivity analysis. We included the years 2017–2022 based on data availability.

The analysis uses the Social Deprivation Index, a composite measure from 1 to 100 constructed by the Robert Graham Center using demographic data from the Census Bureau's American Community Survey, to quantify levels of economic and social disadvantage across small geographic areas. In 2017, the Graham Center updated the index initially developed by Butler and co-authors (2012) and added more geographic areas.[49] High Social Deprivation Index scores correlate with high deprivation. The index allows researchers to analyze associations between deprivation and health outcomes at various geographic levels. Beneficiary-level data was not used for this analysis.

Methods

Using results from the CMS Public Use Files for MSSP ACO, we plotted the distribution of percentage of gross shared savings of all ACOs for each performance year from 2017 through 2022 and calculated median savings across all ACOs by year. The exception is 2019, when some organizations reported only six months of performance data due to entering the program halfway through the 2019 performance year. Results for this cohort are displayed separately in the analysis.

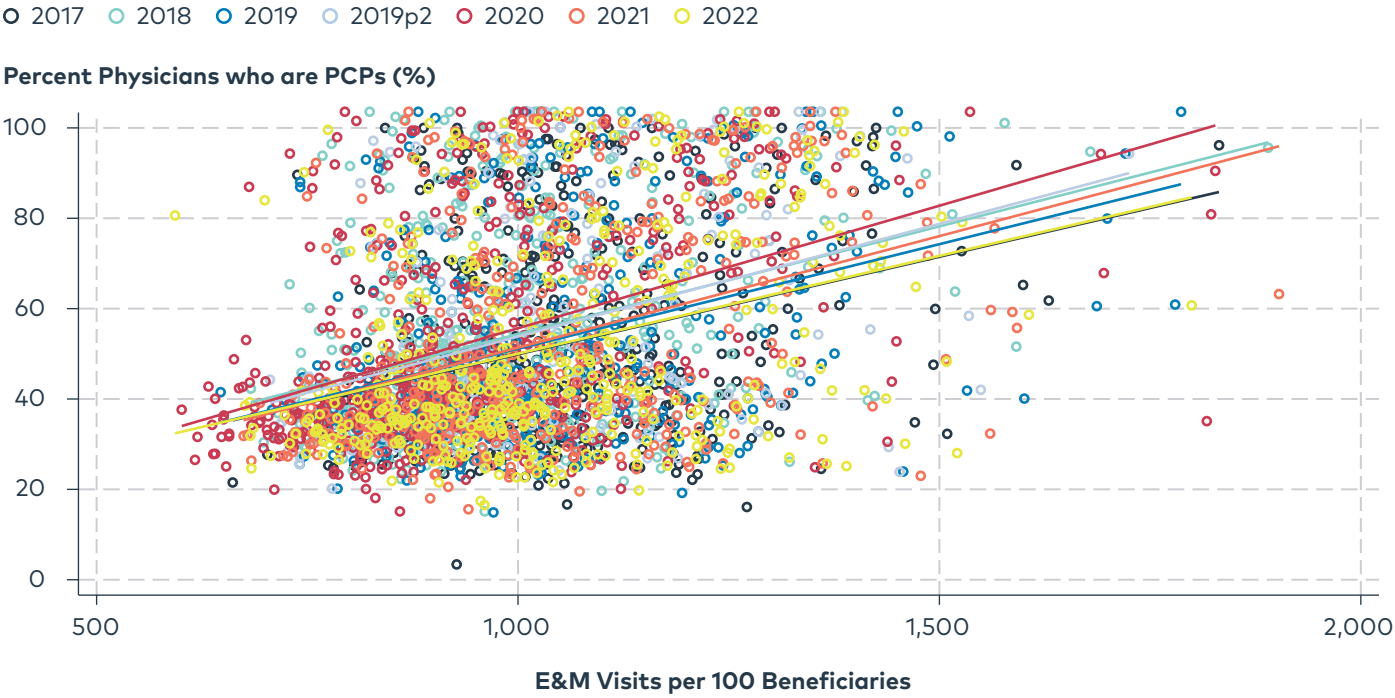
Positive savings percentages indicate that the total (Medicare Part A and Part B) costs for attributed beneficiaries were below the established benchmarks, while negative percentages indicate that total costs for attributed beneficiaries were above the established benchmark for the year reported. To qualify for any shared savings generated, an ACO must first meet a standard of quality performance based on a composite score averaged across a range of standardized quality measures.

The analysis measures primary care centricity using the share of primary care physicians as a proportion of the total physicians participating in the ACO and breaks the measure into quintiles for each year. Another measure of primary care centricity—evaluation and management (E&M) visits with primary care physicians per 100 beneficiaries—was also tested. These two measures of primary care centricity appeared correlated, so the analysis presented uses primary care physicians as a share of all physicians as a measure of primary care centricity. (See Figure 2)

County-level social deprivation indices were paired with the county-level ACO enrollment to create a weighted average score for the entire population of each ACO for each year, allowing analysis of the overall Social Deprivation Index score of the service region for each ACO's attributed beneficiaries. The SDI scores for ACOs are plotted against ACO gross shared savings rates.

FIGURE 2

Percent of Physicians in an MSSP ACO who are PCPs Compared to the Volume of E&M Visits in an ACO by Year



County-level enrollment is directionally helpful, but some counties may have regions with higher and lower social deprivation indices. To check for robustness for the SDI measure, we separately calculated the SDI score based on clinician location at the ZIP code level, which allows for a more granular estimate of a Social Deprivation Index. The findings between the two approaches were similar, and we only included results from the SDI approach using county-level beneficiary enrollment. Beneficiary-level enrollment at the ZIP code (or smaller) geographic level is not available with public-use data.

Results

Primary Care Centricity

Table 1 highlights the consistency of high performance of primary care centric ACOs over six years. For this analysis, we defined a primary care centric ACO as having at least 50 percent primary care physicians as a share of all physicians, and nonprimary care centric ACOs as those with fewer than 50 percent PCPs. Over the period 2017–2022, primary care centric ACOs generated 2.4 times the savings percentage as nonprimary care centric ACOs.

TABLE 1

The Annual Savings Average of ACOs Based on Percentage of Participating Primary Care Physicians (PCPs), High (Greater Than 50 Percent) Compared to Low (Less Than 50 Percent)

Year	ACOs with less than 50 percent PCPs, percent savings	ACOs with greater than 50 percent PCPs, percent savings	Ratio of high percent PCP-to-low percent PCP savings
2017	0.6 %	2.4%	4
2018	0.8%	2.7%	3.4
2019	1.4%	4.5%	3.2
2019.5	2.0%	4.4%	2.2
2020	3.0%	5.5%	1.8
2021	2.4%	5.3%	2.2
2022	2.5%	5.9%	2.4
Avg	**1.8%**	**4.3%**	**2.4**

Further analysis of the PUF also shows that the percentage of beneficiaries in ACOs that have 50 percent of more primary care physicians has also declined during this six-year period, although it is not significantly significant.

TABLE 2

Beneficiary Enrollment in ACOs with Majority PCPs Over Time

Year	# of Beneficiaries in ACOs that Are Less than 50% PCPs	# of Beneficiaries in ACOs that Are Greater than 50% PCPs	Total Beneficiaries	% of Beneficiaries in ACOs that are more than 50% PCPs
2017	6,517,928	2,474,958	8,992,886	27.5%
2018	7,663,015	2,433,859	10,096,874	24.1%
2019	7,763,952	2,233,753	9,997,705	22.3%
2019.5	2,953,157	1,134,671	4,087,828	27.8%
2020	8,283,556	2,331,033	10,614,589	22.0%
2021	7,740,927	2,383,398	10,124,325	23.5%
2022	7,920,371	2,497,926	10,418,297	24.0%

Longitudinal Trends in MSSP ACO Performance

The median measure of savings percentage across all ACOs increased over the period 2017–2022, increasing from 1.1 percent to 3.4 percent. (See Figure 3.) The distribution around the median is normally distributed and has remained similar between 2017–2022.

Figure 4 demonstrates that the percentage of ACO physicians with a primary care specialty declined slightly between 2017 and 2022 and remains near 40 percent overall. A similar modest decline was also seen in primary care E&M visits. While not visualized here, outside analysis found the participation of nurse practitioners and physician associates in MSSP ACOs grew from 27 percent of all clinicians to 36 percent of all clinicians from 2017 through 2022.[50]

The analysis reveals that ACOs in the higher quintiles of primary care centricity (as measured by percentage of primary care physicians as share of all ACO physicians) were more likely to generate savings and generate savings above the median rate of savings for all ACOs over the 2017–2022 period. (See Figure 5.) A measure of primary care centricity using E&M visits produced comparable results.

FIGURE 3

Annual Performance of MSSP ACOs by Year

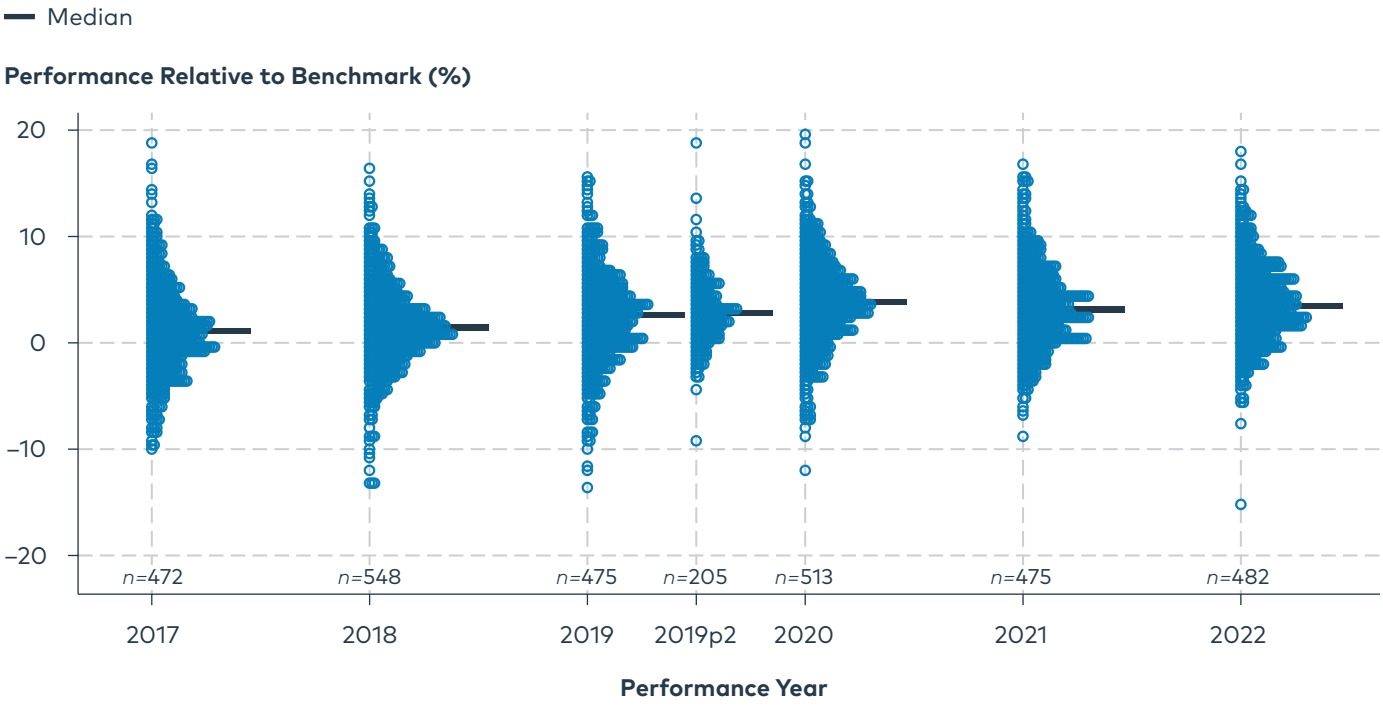


FIGURE 4

Percent of Primary Care Physicians in MSSP ACOs by Year

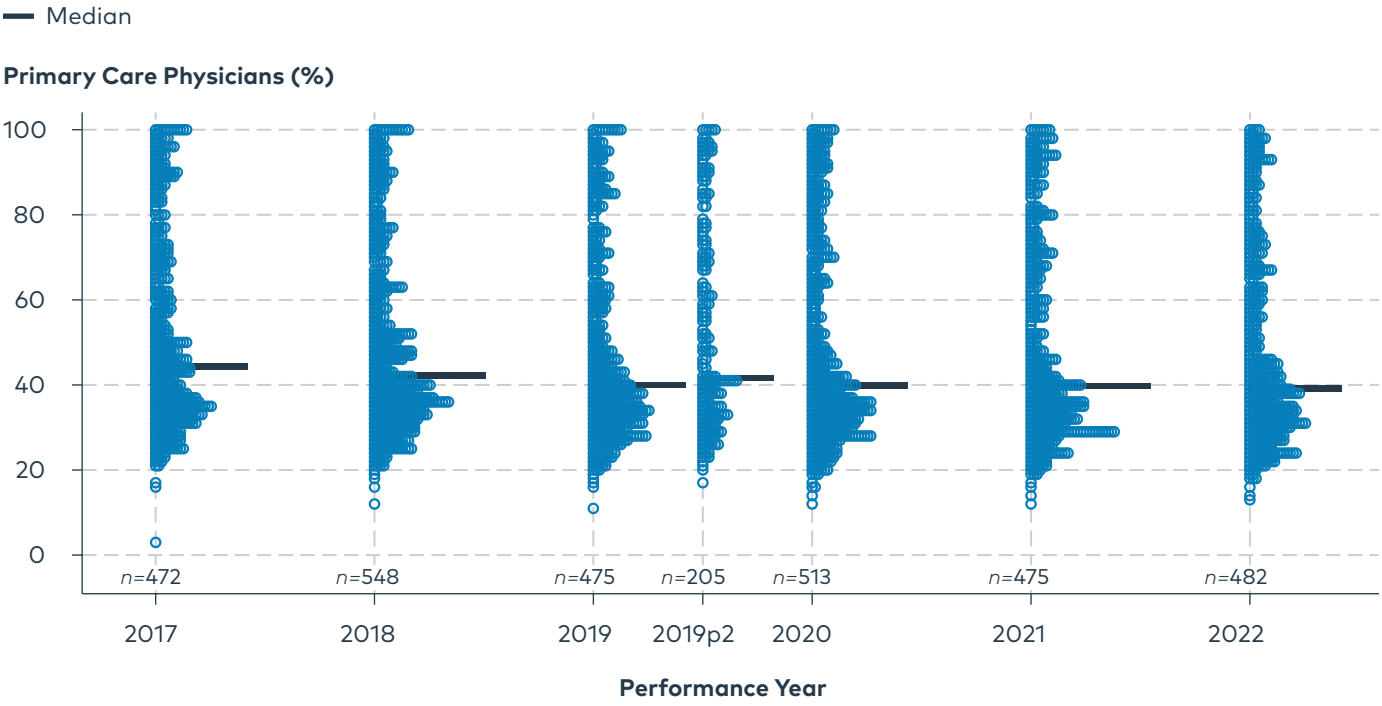
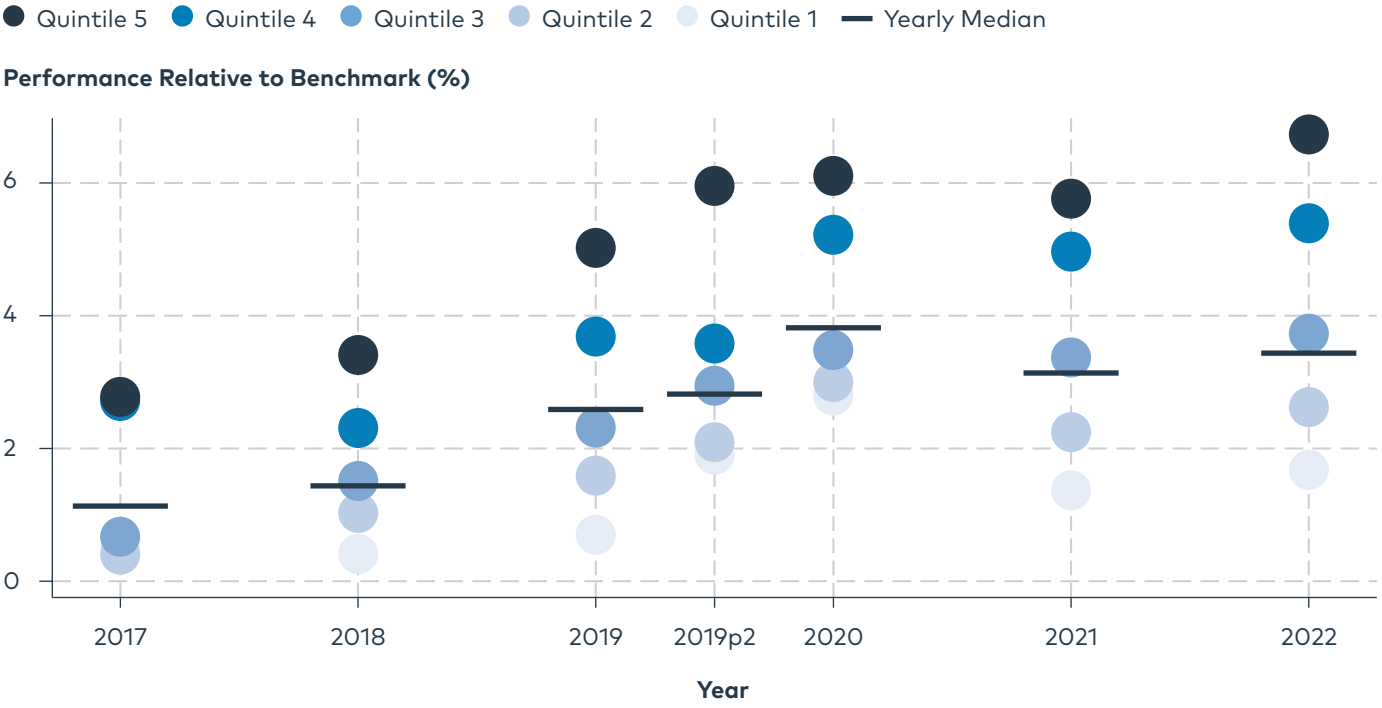


FIGURE 5

MSSP ACO Median Performance by Quintile of Percent of Physicians Who are PCPs by Year



Note: Darkest blue indicates the highest proportion of primary care clinicians in the ACO, while lightest blue demonstrates the least volume of PCPs in the ACO.

Table 3 includes 25 ACOs in the highest quintile of primary care centricity (the darkest blue circles in Figure 4) with the highest gross savings percentages. Their composite quality score and adjusted Social Deprivation Index are also reported.

TABLE 3

The Top 25 High-Performing Primary Care Centric ACOs, PY 2022 (Ranked by Top Quintile of Primary Care-Centricity and Savings). Three Highlighted ACOs are Featured Report Case Studies

	ACO Name	Percentage Savings (gross)	Composite Quality Score (max 100)	County-level Social Deprivation Index (max 100)
1	Physicians ACO, LLC	18%	89	42
2	PA MSSP PMA Enhanced	17%	80	12
3	LA MSSP 2016 Enhanced	15%	91	80
4	PA MSSP Legacy + Gateway Enhanced	14%	88	21
5	Bluestone ACO	14%	71	34
6	Rio Grande Valley Health Alliance, LLC	13%	91	96
7	Citrus ACO	13%	93	41
8	Cumberland Center for Health Care Innovation	13%	93	54
9	Freedom Health Care Alliance, LLC	12%	79	45
10	Alliance ACO, LLC	12%	75	41
11	Primary PartnerCare ACO IPA, Inc	11%	98	17
12	USMM Accountable Care Partners, LLC	11%	71	47
13	MCM Accountable Care Organization, LLC	11%	79	43
14	TP-ACO, LLC	11%	86	41
15	Space Coast ACO	10%	81	44
16	Community Health Provider Alliance	10%	71	43
17	Accountable Care of NEFL, LLC	10%	82	48
18	PMC ACO	10%	80	48
19	GA MSSP Enhanced	10%	82	57
20	OneHealth Nebraska	10%	93	32
21	ACMG Health Systems, Inc	9%	71	54
22	Tri-State KY MSSP Enhanced	9%	97	56
23	Mid-Atlantic Collaborative Care, LLC	9%	86	19
24	Akira Health of Fresno, Inc	9%	85	91
25	Premier Care Community, LLC	9%	81	46

Role of Social and Economic Factors in ACO Service Areas and Performance

Areas across a full range of social deprivation scores were served by MSSP ACOs, without clustering toward lower-SDI counties. The counties served by MSSP ACOs displayed a consistent adjusted median county SDI score of approximately 45 (out of 100) across all six years studied, despite the exit and entry of ACOs in the MSSP over the same period. (See Figure 6.)

We found no association between ACO savings and SDI scores based on either county of beneficiary residence or based on ZIP code of clinician location. (See Figure 7.)

FIGURE 6

Social Deprivation Index Score of MSSP ACOs by Year

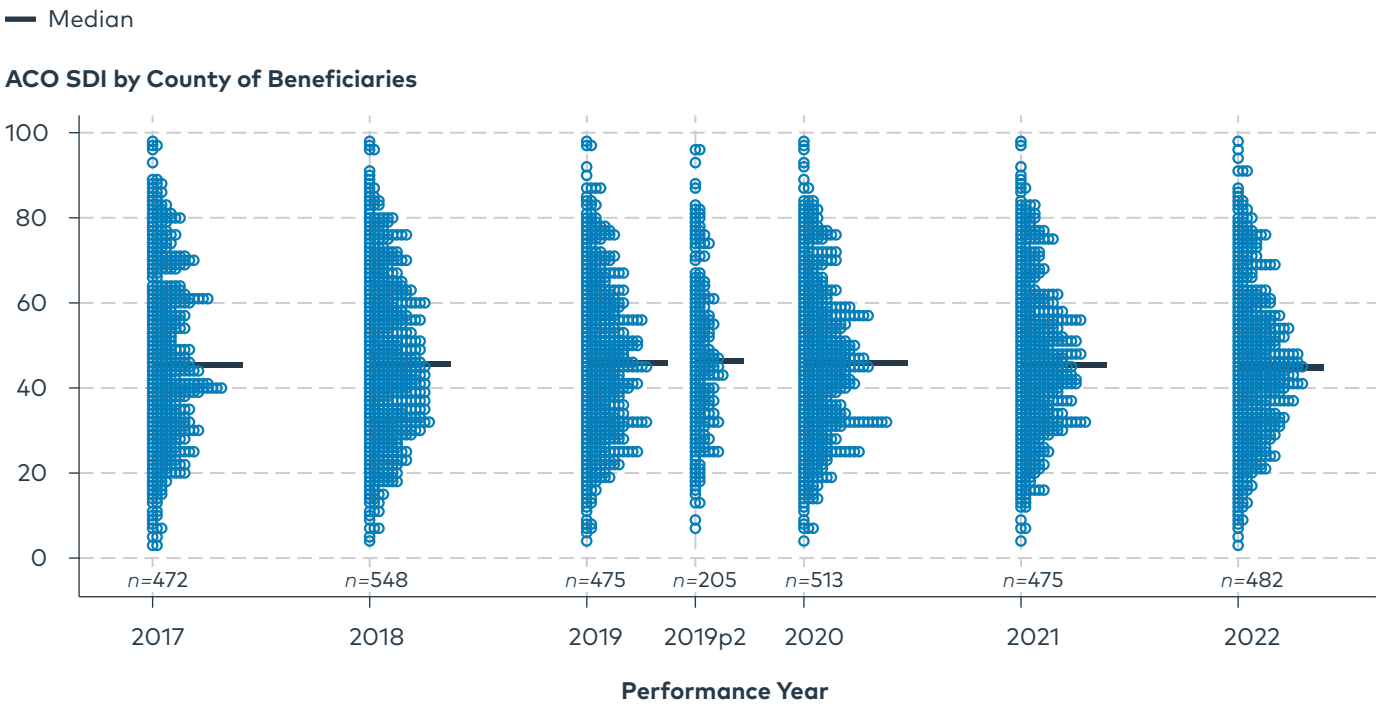
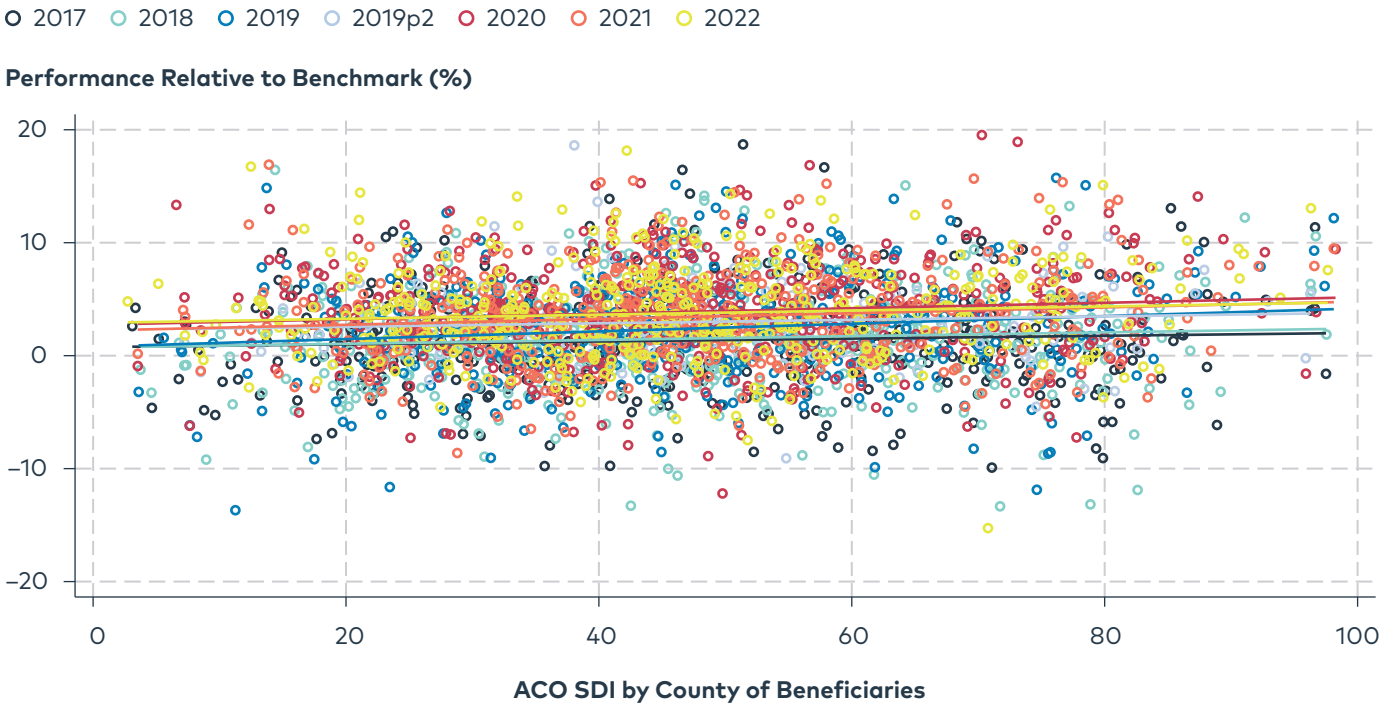


FIGURE 7

Social Deprivation Index of ACO Compared to Performance by Year



Limitations

We cannot infer causation between performance and primary care centricity because the cohort of MSSP ACOs changes over the period studied in a nonrandom way due to the voluntary nature of the MSSP. CMS rules and parameters for the MSSP have also changed over the period studied, and we lack a comparison group of providers not participating in the MSSP.

We did not analyze ACO attributed beneficiary residence data at smaller geographic areas that might have higher or lower Social Deprivation Index scores than county-level scores due to data limitations of the MSSP Public Use Files. There are limitations to SDI as a measure of population need, including its sensitivity to rural-urban differences. We did not analyze beneficiary risk scores and their association with the index or ACO outcomes.

We also were limited to measuring only primary care physicians in our primary care centricity measure because the Public Use Files

do not distinguish between nurse practitioners and other advanced practitioner clinicians who primarily deliver primary care versus those who deliver specialty care. Yet the participation of these professionals in MSSP ACOs has increased, and their E&M services are included in the beneficiary attribution algorithm—but only if the beneficiary has at least one visit with a primary care physician per year. Their participation in ACOs may enable ACOs to reach more underserved communities and improve health equity.

Additionally, we included all clinicians in the percent of PCP per ACO. However, it is possible that this is skewed by non-direct patient-facing care clinicians in the denominator, including pathologists and radiologists.

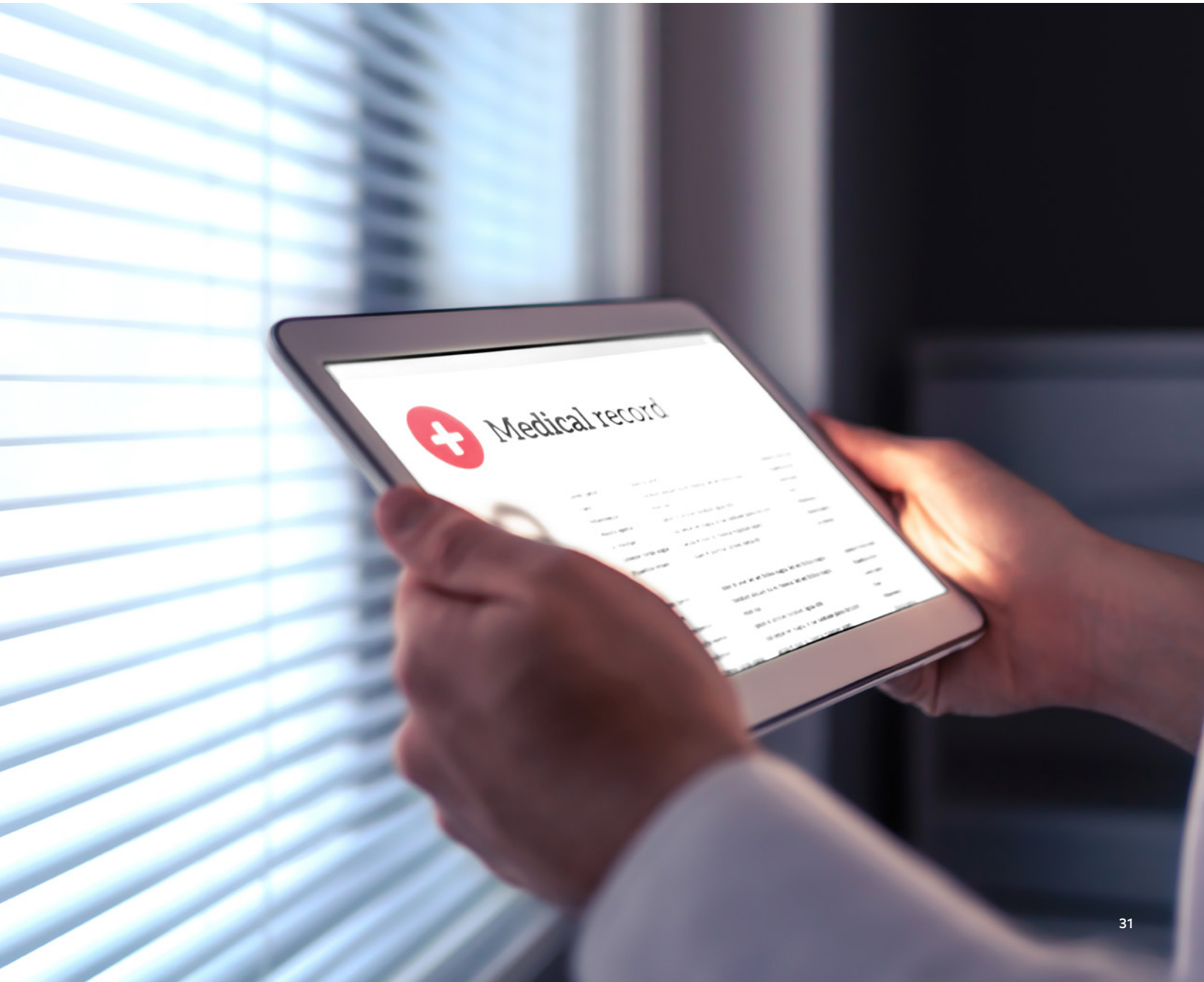
Discussion

The positive correlation of primary care centricity with ACO performance over time in the MSSP demonstrates the value that primary care brings to population-level accountability. Yet median primary care centricity, as measured by PCPs as a percentage of all ACO physicians across all ACOs, did not increase over the period studied and the percentage of Medicare beneficiaries in primary care centric ACOs also declined. The number of E&M visits with PCPs per beneficiary also declined slightly over the period. The increasing participation of nurse practitioners and physician associates may help explain the small decrease seen in the number of E&M visits by PCPs in the analysis. At the same time, the median shared savings percentage improved slightly across all ACOs.

The county-level SDI analysis suggests that ACOs are serving a broad range of beneficiaries, as measured by factors captured by the index, and the ACOs serving beneficiaries in higher-SDI counties are performing similarly to those serving lower-SDI counties. However, the analysis cannot identify if ACOs are avoiding certain beneficiaries living in high-SDI counties. Moreover, the analysis does not capture variation in social services, housing stock or other safety net programs across counties.

The analysis suggests ACOs serving high-SDI counties seem to generate savings at similar rates as ACOs serving lower-SDI counties. This finding is encouraging, but more analysis is needed to study beneficiary-level data, smaller geographic areas with high SDI and beneficiary-level demographic data to better understand if ACOs are serving beneficiaries in all types of communities.

The analysis of ACO distribution across counties by SDI levels suggests a degree of consistency since 2017 in terms of the SDI characteristics of the counties served by ACOs participating in the MSSP. In addition, CMS introduced a health equity adjustment in the MSSP in 2023 intended to incentivize ACOs to serve low-income beneficiaries and those residing in census block groups with a high Area Deprivation Index,[51] which is a metric similar to the SDI used in this analysis. This program change adjusts the ACO quality performance score, which determines eligibility for shared savings, for ACOs serving beneficiaries with higher vulnerability. Future research should examine the impact of this change.



Case Studies

Methods

After determining the top-performing ACOs based on their publicly available metrics, ACOs were then identified for possible interviews. The study team designated three target areas for interview possibilities: high overall performance, most improvement over time and ACOs serving disadvantaged communities (as measured by the Social Deprivation Index and volume of Federally Qualified Health Centers in the ACO).

ACOs were included for interviews if they were in the top quintile for percent of PCPs in the ACO, as compared to all ACOs. Overall performance, improvement and SDI were given a weight between 1 and 3 for each category, with 3 being the highest weight for the specific criteria. The top performers of each category were identified. Using a snowball contact method, the research team reached out to the National Association of ACOs and ACO leadership at various institutions, the National Association of Community Health Centers and cold-contacted the ACOs from each category. ACOs that were reachable, able to provide individuals for a one-hour interview and those that met our inclusion criteria were interviewed.

The research team devised an interview guide based on the literature review, discussion with key informants and internal collaboration. The interview guide included an exploration of governance, facilitators and barriers to performance, health information technology and clinician involvement. Facilitated interviews occurred between July 2024 and October 2024 and lasted approximately 60 minutes. Contacts from each ACO were established for further questions, if any arose. This research was determined by the American Academy of Family Physicians IRB to be exempt.

Case Study 1

LA MSSP Enhanced ACO

Service Area: Louisiana

First Year as an ACO: 2016

Percent of Primary Care Physicians: 77 percent

Number of Participants/Clinics: 29[52]

Number of Beneficiaries: over 15,000

Quality Score (percentile as compared to all ACOs): 91 percent

Gross 2022 Savings: 15 percent

Savings in FY 2022: $7,153,897[52]

Change in Savings Rate between 2017 and 2022: 14 percent

Social Deprivation Index of Community: 79/100

Leadership Interviews:

Nadine Robin,
Market President

Darrin Menard, MD,
Regional Medical Director

Fundamentals

Success did not happen overnight. The Louisiana MSSP Enhanced ACO achieved shared savings in its third performance year. Initially when enrolling, practices made several changes to their processes and practices to attempt to address several quality metrics in order to gain shared savings. However, they shifted their approach in subsequent years, and their solution was to focus specifically on eliminating unnecessary Emergency Department use.

This decision led clinicians to engage patients at high risk for ED use and discuss blood pressure control. Patients were managed, clinicians were able to identify those most in need of support, and ED visits decreased. The experience taught practices to do the basics, become fluid in their process for identifying high-risk patients and follow up with individuals. With this early learning, the ACO has continued a similar approach, acting upon a single clinical area until their quality performance meets the target.

"It's not a magnificent looking plan of action. It's just we do the same thing over and over again, and you will get good results. Kinda like running the football. If you run the football well, you win the game in the trenches. You're gonna get success."

Actionable Insights

Aledade's app is the backbone for sharing practice-specific data insights. It is EHR agnostic, allowing practices to access data insights without additional configuration. The app provides hospital or ER notifications, patient summaries and care gaps to individual practices. It also serves as a platform for daily huddles; these data allow for specific and targeted interventions so patients get the right care at the right time.

The app prioritizes actionable items and work lists for patients with and without appointments. In effect, the app stratifies patients who need services, whether they are scheduled or not. This stratification can spur conversations about a subset of patients and encourage panel management. Metrics that are identified as need areas may warrant a new protocol or workflow. Practice leadership, including Medical Directors, meet with ACO leadership and determine feasibility of a practice intervention. If the newly developed intervention is not viable, ideas for change are elevated to the national level and reformulated. At the local level, different solutions may be presented. Practice improvement is a team effort where Aledade's Regional Market President helps incorporate information that will improve performance at a local level and address larger, national issues.

LA MSSP Enhanced ACO is a partner with Aledade. Aledade is a public benefit corporation and support organization for primary care to assist in success with value-based care models. Aledade collaborates with practices to help achieve revenue growth in the MSSP, provides tools for practice management and electronic health records (EHRs), engages patients and helps support practice staff. Public benefit corporations are for-profit corporate entities that have a mission of public benefit. They are authorized in 35 states and Washington, DC. The board of directors must incorporate nonfinancial interests of stakeholders when making decisions for the company, specifically regarding the social mission of the corporation.

"The app is also the tool that is gonna keep everybody successful. So when we know that there's something that needs to be worked on and a care gap, that information is brought to the practice by the Practice Transformation Specialist and then the practice utilizes the app to be able to get those care gaps done and in efficient manner."

"I think in particular what makes our ACO successful is that they are independent and we embrace that independence and their individuality and the strength of that. And you have to approach that a different way and really build that collaboration with them within the ACO. So I would just say don't fight that. Don't fight it and try to force independent providers into a structured box."

Information Flow

All participating sites of the Louisiana MSSP Enhanced ACO have a seat on the board, and members meet every two months for strategic discussions focused on key performance indicators and trends. They also engage in clinical discussions that highlight opportunities for quality improvement. In alternating months, the Medical Director team meets with practices to dive deeper into data, clinical workflows and best practices. Weekly, Aledade's Regional Market President and the ACO's Medical Director meet and provide information to practice-transformation specialists and the Medical Director's team to discuss practice needs, challenges or successes.

Each practice is provided a practice-transformation specialist who assists with meeting metrics and tailoring interventions for their practice. Practice transformation specialists collaborate with everyone on-site at the clinics (schedulers, nurses, care managers and physicians) to assess workflow and suggest improvements. If care gaps are identified, practice transformation specialists relay that information to the practice, which can then address the gaps through the app. They also communicate any issues back to Aledade, including whether additional support or assistance is needed.

Meeting frequency ensures that everyone is in alignment around goals and is informed of any concerns or solutions. The regular meeting cadence ensures that practice and system goals are aligned, and each individual and practice is aware of and supported in their new initiatives.

Independence and Trust

The importance of independence for the participating practices in the ACO cannot be overstated, with shared savings being key to maintaining this autonomy. Independent practices, especially in rural areas, value the ACO community for its collaboration, data sharing and policy insights. This independence reflects not only in how they practice medicine and relate to one another but also in how they engage with their patients. Aledade supports this by encouraging individuality and independence, with practice leadership recognizing that without the ACO, many of these practices would be forced into employment and lose what makes these clinicians special. They believe staying independent enables practices to take risks and protects patients from unnecessary services, as compared to their employed physician counterparts who do not have as much freedom, and often prioritize financial security and avoid risk.

As the ACO expanded from five to 25 practices and covered lives grew from 5,000 to 15,000, changes needed to be strategic across the ACO due to the increased scale of business. The trust built early on through data-driven success allowed for rapid initial growth and remains central to Aledade's approach, helping practices stay independent and thrive through shared savings.

Unique Solutions

- **Make small transformations:** The ACO sent postcards prior to the holiday season to high-risk patients reminding them to order medications, what holiday hours were and after hour numbers for contact. The goal, and results, demonstrated a reduction in unnecessary ED visits and improved medication management of their chronic conditions.
- **Innovate on a large scale:** The ACO implements care services that make a difference in patient quality of life and improve shared savings, such as advanced care programs or specialized care management programs (kidney care).
- **Become hyper-focused:** The ACO focused on items that positively impacted patient outcomes and achieved shared savings.
- **Promote basic care:** Practices went back to basics and controlled blood pressure with simple tasks, such as using door-hanger reminder to recheck BP before a patient leaves or scheduling two-week follow-up (as opposed to three months), to keep patients out of the hospital or ER.

Recommendations

- **Practice fundamentals:** Become proficient doing a few things well, then tackle the next quality metric.
- **Keep it simple:** Interventions do not need to be grandiose; minimal changes can yield increased shared savings and better patient outcomes.
- **Welcome and value practice particularities:** Allow for practice individuality to flourish; it is their strength.

"It makes such a big difference in a practice when they're independent, to be able to provide quality care to these patients and be able to move the needle real quick for these patients as well to get them better."

Case Study 2

OneHealth Nebraska ACO, LLC

Service Area: Nebraska

First Year as an ACO: 2017

Percent of Primary Care Physicians: 97 percent

Number of Participants/Clinics: 23[53]

Number of Beneficiaries: over 9,400[54]

Quality Score (percentile as compared to all ACOs): 98 percent

Gross 2022 Savings: 10 percent

Savings in FY 2022: $4,611,700[55]

Change in Savings Rate between 2017 and 2022: 8.3 percent

Social Deprivation Index of Community: 32/100

Leadership Interviews:

Brandon Webb, MD FAAFP, Chief Medical Officer and Quality Assurance Officer

Donna Mertz, Compliance Officer

Governance

OneHealth Nebraska ACO, LLC is an Independent Physician Association and ACO. The IPA oversees the ACO. The group has two governance boards with similar positions, but they differ in that the IPA board is composed of primary care and other specialists while the ACO board consists of only primary care specialists (three family physicians, two pediatricians, an internal medicine physician and an obstetrician-gynecologist) and a Medicare patient representative.

The makeup of OneHealth Nebraska's boards demonstrates the importance of primary care involvement. Board members serve three-year terms, ensuring leadership rotation. All 90 clinics vote to elect the IPA board, while ACO clinics, mainly primary care ones, elect the ACO board. Both boards are active, meeting monthly online and moving toward in-person meetings.

The ACO is owned and governed by physician shareholders, emphasizing that the ACO works for physicians, not the reverse. Its structure is lean, with a team of five: CEO, Chief Medical Officer, Chief Financial Officer/Senior Vice President of Operations, Vice President of Clinical Integration and Director of Membership Services and Communications.

The ACO has commercial and Medicare contracts, with the latter operating under the MSSP. Since the ACO takes on downside risk, all clinics have a vested interest of improving quality to improve savings.

"The one thing we do well is to make sure they [the clinics] own this. This is their thing. We work for them. They don't work for us. They are fully responsible for the outcomes of this as well. So it takes a little pressure off of us, but we do try to herd the cats."

Autonomy and Physician Leadership

OneHealth Nebraska ACO is a mission-driven organization that supports independent and locally owned primary care practices. It does not direct clinics to work on specific tasks, but rather, the ACO leadership helps clinics understand measurement and decide upon their own resourcing and workflow. The ACO believes clinics know what works best for their own team and allows individual clinics to tailor solutions for their own particular needs. ACO leadership does not interfere with the clinics' creative process. Clinics may develop their own innovative solutions (via games and competitions). These methods are shared during ACO care coordinator meetings for potential adoption by others. The ACO allows clinics to stay independent while providing financial opportunities and support.

Success hinges on three key roles: a lead physician to champion value-based care, a care coordinator to manage quality metrics and an administrator to oversee operations. Additionally, clinics must complete an onboarding process and use the American Board of Family Medicine's PRIME Registry for data documentation and reporting, helping them achieve success in the ACO.

Reporting

Reporting is critical for success, enabling clinics to target patients who need preventive care. With nine different EHR systems across clinics, data are sent to the ACO, which compiles and submits it to Medicare. The ACO pays for and uses the PRIME Registry to manage an ACO-level dashboard (board-certified family physicians receive PRIME Registry access free of charge). Clinics own the license to PRIME Registry, empowering them to customize metrics and interact with the PRIME Registry directly.

For the ACO to best meet clinic needs, it accesses the essential functions and metrics in PRIME Registry and is also able to view basic cost information. The ACO does not focus on process details but rather on collective success, with all clinics contributing to shared outcomes in the MSSP. Monthly lead physician and care coordinator meetings help clinics compare performance, share best practices, and work together to improve metrics.

Patient-Centered Approach

A patient-centered approach goes hand-in-hand with primary care. OneHealth Nebraska ACO notes that patients may select primary care because of their relationship with the clinician. The ACO looks for ways to benefit patients and their relationship with a practice, improve physician workflow and save money. One approach is to improve team-based care; physicians can manage complex care for patients while licensed practical nurses or care coordinators focus on preventive care. While LPNs or care coordinators may be viewed as an added expense for some clinics, at OneHealth Nebraska, these team members provide support for clinicians and improve focus during a patient visit. Overall, this investment has resulted in shared savings.

The ACO leadership also helps clinics improve their quality metrics and savings by pairing well performing clinics with those in need of workflow assistance. It is in the best interest of clinics to make needed adjustments, as shared savings are achieved together. The more individual clinics who are able to achieve quality metrics and reduce spending, the more savings for all practices. Leadership meets with all clinics annually in-person to discuss what measures are most valuable to improve patient health.

"There's a certain thing about going into primary care that you're doing it because you really have a heart for people... [Y]ou don't have to sacrifice what's right for your patients to do better financially. And I think there was a point where it's like, well, I'm just going to see 40 people a day, which means I'm not going to give the best care to everybody if I'm just gonna slug it out like that because I want my bottom line to be better. I can make my bottom line better and do better for my patients, and that's a real difference. That feels different to me as a provider. Try to get to that place this way with better tools and a team around me that I can share the burden with others like my nurse, my care coordinator. Frankly, my whole stack, my schedulers, my billers, my coders, they're all on the page about why we do what we do and how we do it."

"I would say without exception, the main reason they do the things they do is because they want their patients to do well and that's why they got into it. That's why you get into primary care. If you get into it for money, you're not going to go to primary care."

Unique Solutions

- **Promote physician ownership of practices:** The ACO includes physician-owned practices, with little overhead.
- **Focus on investments that matter for both patients and practices:** The practices focus on measures that have a positive impact on patients and improve clinician satisfaction.
- **Utilize PRIME Registry:** The team uses this low-cost (or potentially free) tool to help clinics collate data from their EHR system and report to CMS.

Recommendations

- **Keep it simple:** Data analytics can be costly. Limit collection to what is actionable.
- **Know costs:** Make collaborative agreements with like-minded stakeholders to leverage best quality and inexpensive solutions with high value.
- **Do not sell private practice to a corporation:** The corporation may not align with the clinic's personal or business values.
- **Drive best practices**: Let practices figure out what works best for them, then disseminate the information with others.

Case Study 3

Community Health Provider Alliance

Service Area: across Colorado, in both urban and rural areas

First Year as an ACO: 2014; Participated in the MSSP in 2017 and shared savings in 2019

Percent of Primary Care Physicians: 80 percent

Number of Participants/Clinics: 20 Community Health Centers, 19 in MSSP ACO, 1 Indian Health Clinic [56]

Number of Beneficiaries: over 857,000[56]

Quality Score (percentile as compared to all ACOs): 70.6 percent

Gross 2022 Savings: 10 percent

Savings in FY 2022: $7,482,313[57]

Change in Savings Rate between 2017 and 2022: 14.3 percent

Social Deprivation Index of Community: 42/100

Leadership Interviews:

Jason Greer, Interim Chief Executive Officer

Brandi Apodaca, RN, BSN, Chief Operations Officer

Governance

CHPA's governing board consists of a diverse mix of executives and representatives from many of the participating Community Health Centers (CHCs), but not all of them. This board serves as the key decision-making body, particularly when it comes to implementing accountability measures. The board has two subcommittees: the finance committee, which handles the financial flow and ensures ongoing success, and the clinical committee, which focuses on performance and educational activities. The clinical committee also fosters a culture of accountability among clinicians.

Despite its large size, the CHPA itself operates with a lean organizational structure. In 2020, it had only four employees serving 15 clinics, and that year marked the first distribution of funds, which increased clinic interest and participation in the ACO. That was also the first year of shared savings, so clinics became more invested in participation. Today, the CHPA employs about 20 people, but it remains small enough that clinicians and clinics maintain multiple points of access to the ACO leadership team.

Clinic Engagement

Given the diverse patient population needs across the state, the CHPA offers minimal standardized support. Rather, it opts for a clinic-specific approach in which it identifies potential issues within individual clinics and provides tailored assistance. For example, Community Health Centers historically have struggled with risk adjustment scores, which often fail to fully reflect the complex needs of the patients they serve. To address this, the CHPA established a team of Certified Professional Coders and Certified Risk Adjustment Coders. This team engages in

"So we're making sure that we're out in the CHCs. We try to be out there at least a couple of times a year. I'd like to be out there once a quarter at least by someone, whether it's the medical director or me [COO] or the transformation coach or the risk adjustment person. But they know that we're really an extension of [them]. We are here to help, to support. Think of us as another employee who's here. You know, we're not an auditor. We're not coming in to like you don't need to hide your baggage from us. Let's get into it and really have that relationship where we have enough trust that you will share with us what you're really dealing with and that let us help you overcome those. That relationship, and then with data that you can trust, are really important. It's nothing worse than showing up with bad data. That is a quick way to make everything unravel. And so I think those two things have been really, really important."

previsit planning with each clinic, offering targeted recommendations to improve coding practices. The approach is personalized, with clinics either receiving training from the CHPA or implementing their own education. By improving their coding, the practices receive credit for the complex work in which they engage.

A clinician-led transformation team also plays a pivotal role in supporting CHCs. This team provides data that help clinics stratify their patient populations and identify opportunities for process enhancement and quality improvement. The Quality Improvement teams—composed of leadership such as Chief Medical Officers, Medical Directors or Quality Improvement nurses—meet monthly, and the transformation team focuses on clinic-specific areas for improvement. They also provide learning lab opportunities, where clinics can focus on specific disease states, such as diabetes, to refine a process that improves patient outcomes.

Additionally, CHPA's Medical Director collaborates with clinics on operational excellence, meeting a few times a year to discuss overall clinical strategy. Best practices are shared across clinics, particularly when clinics develop a successful method. Lunch-and-learns also serve as valuable opportunities for disseminating best practices and educational learnings.

"The more we get into the value based care, the more data becomes key to success. And we can't continue to have different sources of data, right? We can't use Anthem's portal for our Anthem contract, Humana's portal for our Humana contract, and this portal for MSSP contract. We need all of those activities merged into a single source of truth."

Data

Actionable data is a cornerstone of CHPA's efforts to support member clinics in achieving population health success and improving shared savings. Over time, CHPA's data approach has evolved. Originally, they relied on claims data only, but these data were limiting and did not offer a comprehensive picture of patient health. Now, it has integrated EHR data into its system as well. Both claims and EHR data are housed in the same data warehouse, providing more insight regarding patient outcomes and clinic performance. In fact, there are approximately 15 different data sources that are used to steer informed decision-making to maximize performance.

Alignment

The CHPA views clinic and leadership alignment as a critical process in its past, current and future success. Whether it's through its mission, clinic interactions or opportunities for improvement, alignment can be found at every level of the organization. CHPA's mission, "to improve the quality and cost of care for the people our members serve," resonates with CHCs, which are committed to improve population health outcomes. CHC members have an integrated care approach, offering dental, medical and behavioral health services. This integrated care approach reinforces health equity and equality tenets—caring for all member patients.

CHPA's alignment is further illustrated by the lessons learned from MSSP participation. These learnings could be applied to future statewide Medicaid managed care contracts.

Alignment is also demonstrated at the clinic level: CHC leadership buy-in, targeted engagement opportunities and education and sharing best practices, among others, to provide the best care for members' patients. To further support clinics and ensure alignment, the CHPA is currently implementing Innovaccer (a technology platform) so it can manage the quality and cost performance of individual value-based care contracts.

Unique Solutions

- **Intentional focus:** The CHPA has concentrated on one or two measures and does those well, and it builds on small successes.
- **Have a flexible team with multiple access points:** Even though the transformation team meets monthly with clinics and is their main point of contact, clinics may reach out to CHPA ACO leadership at any time.
- **Continued innovation:** The ACO continues to look for opportunities to strengthen outcomes. Specifically, learning labs were designed to address one or two measures, and this has led to marked quality improvements.

Recommendations

- **Leadership buy-in:** It is easier to implement ideas when leadership agrees or promotes within clinic versus seeking support at all levels; more opportunities exist to diversify revenue and improve outcomes.
- **Build trust:** Trust derives from a shared mission, relationships, and actionable data.
- **Hire those with deep ACO knowledge:** ACO experience matters when building, sustaining, and growing an ACO and its member network.
- **Keep health care local:** Clinics know their patient populations the best and operate with strong, competent teams; the ACO supports them.

"I'd say the tip is a really nice job of making the conversations about quality and about population health and about equity first, because that's what resonates with the health centers and that's how they think about populations. And then as a byproduct of that then program performance comes into play, but, but most importantly, when we talk about about health equity and equality, making sure everybody has the right care."

Policy Options

The evidence for the important contribution that primary care makes to the performance of MSSP ACOs has been documented consistently since 2017. Despite this growing evidence, the CMS program has not attracted more primary care physicians to form primary care centric ACOs. In fact, the percentage of primary care physicians in the MSSP as a percentage of all affiliated physicians has slightly declined. This important data point, however, needs to be seen in the context of a shrinking PCP workforce relative to physician specialists, and growing numbers of nurse practitioners and physician associates practicing in ACOs.

CMS's introduction of MSSP ACO Primary Care Flex, with an effective implementation date of January 2025, may help change this trajectory and is a welcome addition. A voluntary model—being tested by the CMS Innovation Center as a potential permanent MSSP pathway—ACO Primary Care Flex is focused on driving more investment through hybrid payment, a flexible upfront monthly payment combined with fee-for-service payments, to primary care. It is available to "low-revenue ACOs" (about 57 percent of all ACOs), which generally are physician-led, not hospital-led. ACO Primary Care Flex also provides a one-time advance payment of $250,000 as an incentive to establish a new MSSP ACO, which ACOs are expected to repay when they generate future savings.

Yet less than half of primary care clinicians participate in value-based models, and the nation's arguably most successful large-scale value-based care model has flatlined.[58] Other policy options that CMS, the U.S. Congress, and philanthropy could consider to strengthen primary care within the MSSP fall into three main buckets: better research, data and guidance; enhancements for beneficiaries; and enhancements for primary care centric ACOs.

Better Research, Data and Guidance

To enhance research of this successful value-based model, improvements to workforce data and measurement of spending patterns are needed. CMS has taken some recent steps with the Medicare Advantage Data RFI and should also do so with the MSSP.[59] Although the CMS MSSP Public Use Files is a valuable, timely resource, additional data elements could assist researchers to answer other important questions to support further program evolution, including the following.

- **Enhance workforce data collection and reporting.** There are billing and reporting changes that CMS could make to provide a more comprehensive picture of the primary care workforce. Specifically, as MedPAC suggests, CMS could remove "incident-to billing" where advanced practice practitioners bill under a physician license. This is a vestige of a bygone area when these providers could not bill Medicare directly for the services they deliver. In addition, CMS could require that nurse practitioners and physician associates declare their specialty (as physicians are required to do) for CMS reporting purposes. Removing incident-to billing would not change scope-of-practice laws, including state laws related to supervision or collaboration, nor would it require changing the way care is delivered. However, steps would need to be taken to make sure that any revenue a practice loses by no longer using incident-to billing—advanced practice practitioners bill at 85 percent of physician rates—would not be lost to the practice. This is a regulatory change that would not require legislative action.

- **Replace the low-revenue versus high-revenue MSSP ACO distinction with a new composite measure of primary care centricity that is more robust and provides more transparency.** This new measure could include percentage of spending on primary care services, percentage of primary care clinicians, percentage of E&M visits delivered by primary care clinicians and percentage of spending on behavioral health services. The existing low- versus high-revenue distinction is less relevant as MSSP ACOs restructure their TINS to be eligible for program tracks and benefits only available to low-revenue ACOs. Further, a standardized measure across all MSSP ACOs would help compare them on a key metric that is correlated with cost savings and provide more transparency on whether funds are flowing to primary care to enable them to provide more comprehensive, team-based care. CMS could make this change through rulemaking.

- **Provide a better roadmap for practices and ACOs considering joining or staying in various accountable care models.** Increasingly, CMS offers options in the accountable care space, which is positive, given organizational heterogeneity. However, practices and ACOs need objective guidance on which model is most beneficial, and CMS could help fill this gap.

MSSP Enhancements for Patients

Nearly half of beneficiaries in traditional Medicare are aligned with an ACO. Recently, CMS has taken steps to educate them about ACOs, Medicare Advantage and value-based care concepts. There are additional steps that CMS could consider for the MSSP to enhance beneficiary engagement with primary care and to offer more comprehensive primary care services, including the following.

- **Waive Part B cost-sharing requirements for beneficiaries who obtain care from their chosen source of primary care within the MSSP ACO.** This could provide a financial incentive to beneficiaries without Medigap insurance or with Duals coverage (when someone receives both Medicare and Medicaid benefits) to establish and maintain a continuous relationship with primary care, which evidence shows enhances population health. It is particularly important in light of the reality that beneficiary attribution methods vary (prospective and retrospective), and that most beneficiaries do not know they are in an ACO. In addition, this would smooth the path for primary care prospective payment for beneficiaries who do not have Medigap policies and would be subject to monthly copays under hybrid payment. Kaiser Family Foundation estimates that 3 million beneficiaries (11 percent) in traditional Medicare do not have Medigap policies and are fully responsible for cost sharing.[60] Some REACH ACOs are voluntarily waiving beneficiary copays. This change would require legislative action; CMS does not think it has authority to waive cost-sharing outside of a CMS Innovation Center ACO model such as REACH.

- **Incent more comprehensive primary care in the MSSP, starting with behavioral health integration.** Given the evidence about population health gains and reduced costs with behavioral health integration, CMS should incent MSSP ACOs to integrate these services into primary care.[61] At least one study shows that MSSP ACOs are underperforming with respect to behavioral health.[62] Start by adding behavioral health integration incentives

to ACO Primary Care Flex through tiered hybrid payment and by removing behavioral health services from the utilization data that contributes to cost benchmark assessment. Under current benchmark assessments, MSSP ACOs that add behavioral health integration are penalized for increasing service utilization. This enhancement to a new program track would require an update to program rules.

Enhancements for Primary Care Centric ACOs in the MSSP

To derive higher performance within the MSSP ACO program, policymakers should consider additional ways to strengthen primary care centric ACOs and attract more to the program by providing them with more funds, including a higher-risk track, higher levels of shared savings, and higher advanced payment model bonuses, as well as more nonfinancial support. Commonwealth Fund's recent qualitative study underscores the importance of more substantial upfront and value-based payments to attract primary care practitioners off the sidelines into value-based models, such as the MSSP.[63]

- **Create a new pathway within the MSSP that allows for primary care capitation for new and existing ACOs, starting with primary care centric ACOs.** ACO REACH, a CMS Innovation Center model, allows for primary care capitation, and some MSSP ACOs have transferred to ACO REACH with the promise of more flexible payment and more reward if they meet performance benchmarks. This pathway should be available in the permanent CMS program. CMS has expressed an interest in exploring such a pathway in the MSSP in requests for comment regarding a higher-risk track in the MSSP accompanying both the CY 2024 Medicare Physician Fee Schedule Rule and the CY 2025 proposed rule.[64,65] ACO REACH also is set to expire in 2026, and participating ACOs thus are exploring next steps. This is a change that could be made within administrative authorities.
- **Consider increasing the shared savings rate for primary care centric ACOs and offering additional flexibilities as incentives to attract the type of organization that tends toward higher performance.** Given the growing evidence about what produces shared savings within the MSSP, policymakers—through either CMS regulation or legislative action—could increase the percentage of shared savings that would be available to primary care centric MSSP ACOs that meet performance benchmarks,

as well as offer other regulatory flexibilities. This potentially could spur hospitals and hospital systems to employ a greater percentage of primary care clinicians to incent the delivery of more primary care services. Modeling should be undertaken to understand if offering increased savings for primary care centric ACOs would be paid for over time with a growing number of higher performing MSSP ACOs in the program.

- **Direct additional incentives for participation in Medicare advanced payment models (such as APM Bonus) to primary care practices participating in ACOs.** Current APM arrangements are based on a percentage of clinician revenue and so favor higher-paid specialists over primary care, reinforcing existing fee schedule inequities. Congress should consider how to reorient the bonus to better support primary care.
- **Provide more nonfinancial support to primary care centric ACOs,** including strengthening the existing learning community sponsored by the agency and considering how else (see recent CMS and CMS Innovation Center efforts) to improve data sharing to inform decision-making. This could include standing up a public data aggregator to provide real-time clinical and performance data results at a low- or no-cost option to primary care centric ACOs that may not have such infrastructure. PCC's 2018 literature review, and the case studies within it, suggest the important role that data and technology play in ACO success with respect to population health management and closing care gaps to reach benchmark performance goals.
- **Review MSSP ACO governance structures to assure that primary care is well represented.** CMS should consider reviewing governance structures to make sure that there is adequate representation of primary care clinicians and consider setting targets, as they have for REACH ACOs.

The policy options above may attract more primary care centric ACOs to join or expand their reach within the MSSP, providing the kind of team-based comprehensive care that improves health, reduces inequities, and curbs costs by shrinking unnecessary specialty and hospital visits.

Yet the unfortunate reality is that there is a shrinking number of independent primary care practices that could respond to this proposed more favorable policy environment. Current data suggest that approximately 20 percent of physicians are independent of hospitals, insurance companies or venture-backed private equity organizations.[18] Policies should also be considered to further support independent primary care.

The Congressional Budget Office suggests several policy options directed at hospitals and health systems that, to date, have not participated in or dropped out of the MSSP.[1] These include policies that such entities could avoid by forming an MSSP ACO, including site-neutral payments applied to hospital outpatient departments, exclusion from 340B drug-pricing programs, and exclusion from payment for telehealth services. These actions may result in hospitals and health care systems joining the MSSP, but if they do not adopt more of a primary care orientation, their performance gains may remain minimal.

Consequently, it is incumbent on policymakers to consider changes to better align hospital incentives with those incentives facing independent primary care practices and primary care centric ACOs. When all practices, clinics and clinicians in the system are significantly incented to make gains in population health, affordability, equity and efficiency, we will be better poised to dramatically shift U.S. health care to health and wellness. With the decline of the nation's health and a shrinking primary care workforce, it is urgent that policymakers do so.

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The AAFP's Robert Graham Center aims to improve individual and population healthcare delivery through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels. The information and opinions contained in research from the AAFP's Robert Graham Center do not necessarily reflect the views or policies of the American Academy of Family Physicians.

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