INSTITUTE FOR ADVANCING HEALTH VALUE
AT WESTERN GOVERNORS UNIVERSITY

In-Depth Analysis of 2021 MSSP Performance Results

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This brief analyzes the 2021 performance data, sharing high-level program performance and examining savings across participation tracks, by the provider type, size and location of ACOs, and their experience in the program, and reflects on the future of the MSSP in light of the recently proposed changes to the program and the beginning of CMS's new capitated total cost of care model, ACO REACH.

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On August 30th, 2022, the Centers for Medicare & Medicaid Services (CMS) released the 2021 performance results for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) – the agency's largest accountable care initiative. The results come at an important time for the MSSP, following the recently proposed updates which would represent some of the most significant changes since the program's inception.

This brief analyzes the 2021 performance data, sharing high-level program performance and examining savings across participation tracks, by the provider type, size and location of ACOs, and their experience in the program, and reflects on the future of the MSSP in light of the recently proposed changes to the program and the beginning of CMS's new capitated total cost of care model, ACO REACH.

High-Level Program Performance

The 2021 performance year marks the fifth consecutive year that the MSSP has generated net positive savings to CMS while simultaneously reporting high quality performance results for its participants. Although down from $4.1 billion in 2020, ACOs collectively reduced Medicare expenditures by an impressive $3.6 billion in 2021 compared to the program's benchmark spending goal. The drop in overall savings resulted from both reduced ACO participation—38 fewer ACOs than in 2020—and lower ACO performance, with the average ACO generating net savings of roughly $100,000 less than in 2020. (Institute's 2020 MSSP results analysis here)

After accounting for over $1.96 billion in shared savings payments made to ACOs, CMS realized a net savings of $1.66 billion, just $200 million shy of 2020's record high savings (Table 1). Average net savings in 2021 amounted to $164 per aligned beneficiary, down from $175 the prior year, but nearly double the $85 per beneficiary saved in 2019. The average ACO quality score was 90%, with almost all (99%) ACOs meeting the quality standards required to share in savings. Of the 475 ACOs who participated in in the program, 81% achieved savings for Medicare while 58% also earned shared savings for their performance.

TABLE 1: NET PROGRAM SAVINGS/LOSSES OVER TIME

PY	2013	2014	2015	2016	2017
Net Loss/ Gain to CMS (Millions)	-$82.3	-$49.8	-$216.0	-$39.3	$313.7

PY	2018	2019	2020	2021
Net Loss/ Gain to CMS (Millions)	$739.4	$1,200.0	$1,860.0	$1,660.0

In 2021, the 475 ACOs participating in the MSSP represented over 10.1 million covered lives across the nation, down from the 513 ACOs covering 10.6 million beneficiaries the previous year. The program has experienced slower growth in recent years, since the introduction of Pathways to Success (Pathways) required ACOs to move more quickly to downside risk. Additionally, 2021 was a particularly poor year for program growth due to COVID-19, as CMS did not allow any new ACOs to join – a first in the MSSP's history. The recently proposed updates aim to reinvigorate interest in the program, helping to drive greater adoption of new entrants and retain more existing participants.

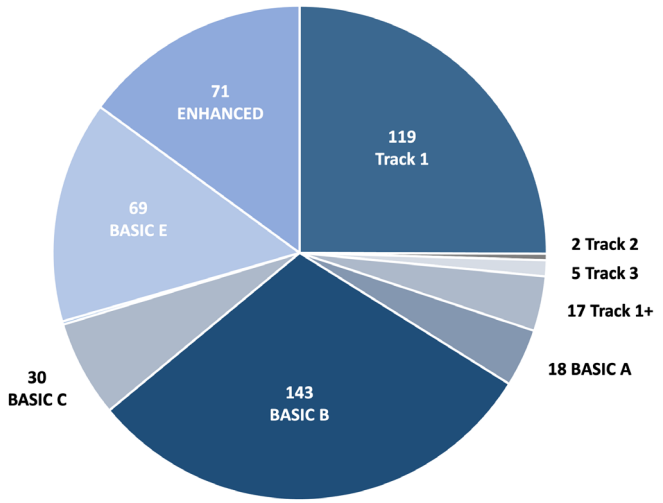
Although no new ACOs were added to program in 2021, 272 of the 308 ACOs that were up for renewal (88%) chose to extend their participation in the MSSP by signing on for an additional performance period. An additional 46 "re-entering ACOs"—participants entering into a second or subsequent agreement period after not participating for one or more performance years—were also admitted into the 2021 cohort. According to CMS data, over 65% (310) of PY2021 participating ACOs were in their second or third MSSP agreement period, leaving only 165 participants with little previous experience in the program. Finally, two ACOs dropped out of the program during the performance year, leaving 475 PY2021 (Table 2).

TABLE 2: PY2021 ACO PARTICIPATION TYPE

NEW ENTRANT ACOs	0
CONTINUING ACOs	157
RENEWING ACOs	272
RE-ENTERING ACOs	46
DROP-OUTS	-2
TOTAL PY2021 ACOs	**475**

While the enhanced risk-sharing requirements under Pathways to Success have led to slower year-over-year participation growth, the proportion of MSSP ACOs bearing financial risk has never been higher. By the end of 2021, despite the overall drop in the number of ACOs, 195 ACOs were in a track featuring downside risk, up slightly from 190 ACOs at the start of 2020. Likewise, the number of beneficiaries covered by a risk-bearing ACO grew by 4% in 2021, reaching 44%. Figure 1 shows the breakdown of PY2021's 195 risk-bearing ACOs by participation track. As in previous years, the ENHANCED and BASIC E tracks continue to be the most popular risk-bearing options—making up almost 72% of total risk-bearing participants—because of their similar designs to Track 3 and Track 1+, the most popular legacy track equivalents, respectively.

Figure 1: PY2021 Risk-Bearing ACOs by Track

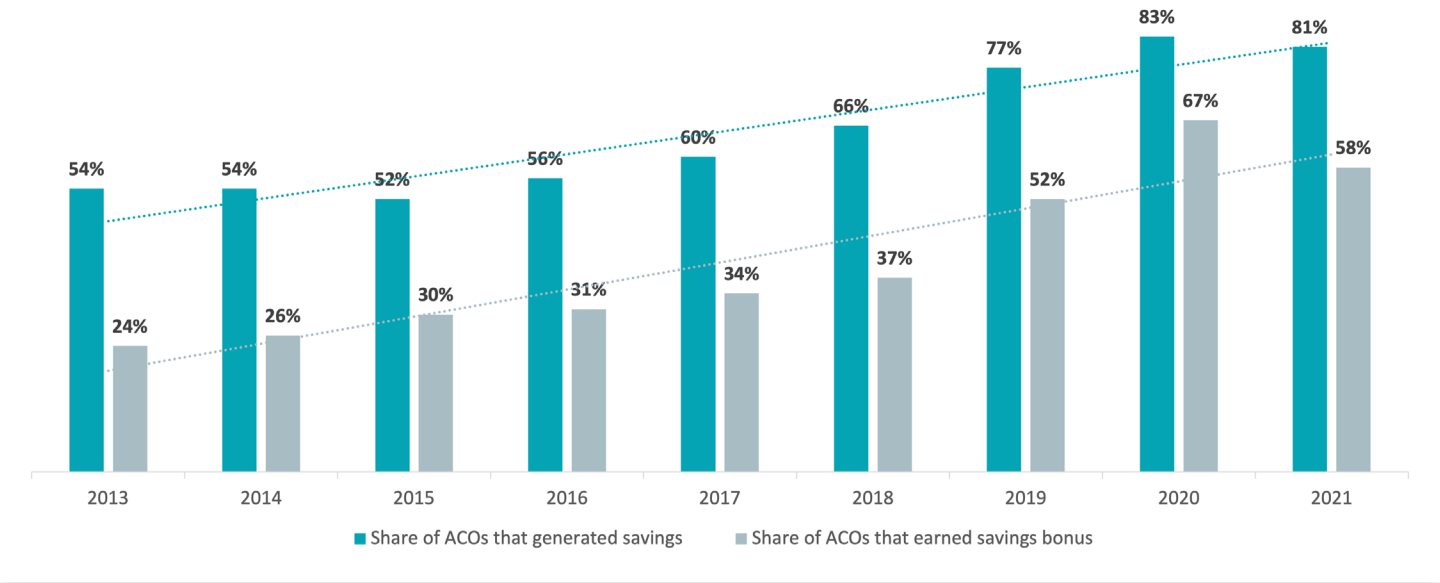


Examining ACO Performance

Although ACO performance saw a slight decline in 2021 relative to the record savings of 2020, it still represents the second strongest year for MSSP savings, continuing the positive trend in performance. Eighty-one percent of ACOs reduced their actual expenditures relative to the projected spending target or benchmark, just under the high of 83% in 2020. However, only 58% of ACOs reduced expenditures enough to qualify for shared savings, a sharper drop from the 67% of ACOs that earned a shared savings bonus in 2020 (Figure 2). The following sections examine ACO performance by track, ACO provider type, revenue designation, size, state, and years in the MSSP.

Many of the methodological updates and flexibilities made to the MSSP in 2020 in response to the COVID-19 Public Health Emergency (PHE) remained in effect throughout 2021 (see Appendix A). Because of this, researchers can more easily draw comparisons between the 2020 and 2021 performance years.

Figure 2: Share of ACOs Generating and Earning Savings



PERFORMANCE BY TRACK

As with years past, ACOs in a downside risk track outperformed participants in upside-only arrangements in 2021, with 89% of risk-bearing ACOs generating savings compared to only 76% of upside-only ACOs. Risk-bearing ACOs also saved more overall with an average savings rate of 4.7% and $189 per attributed beneficiary, compared to only 2.5% and $144 per beneficiary in non-risk-bearing ACOs. This performance resulted in an average ACO savings of $4.3M per risk-bearing ACO and $2.9M per non-risk-bearing ACO in 2021. (See Table 3 for MSSP participation options by risk track).

TABLE 3: MSSP TRACKS LEGEND

	Upside-Only Tracks	Downside Risk Tracks
Legacy MSSP Pathways to Success	Track 1 BASIC Levels A and B	Tracks 1+, 2, and 3 BASIC Levels C, D, E and ENHANCED

ACO performance also varied across participation tracks, particularly when comparing the 70% of ACOs participating in a "Pathways" track (i.e., BASIC Level A, B, C, D, E, and ENHANCED) and the 30% of ACOs who remain in a "Legacy" MSSP track (i.e., 1, 2, 3, and 1+) (see Tables 4 and 5). In general, ACOs participating in Pathways tracks were more likely to generate savings (86% of ACOs) than those in Legacy tracks (71%). Pathways ACOs' per-beneficiary savings more than doubled Legacy ACOs' ($201 vs $85).

Most Pathways ACOs generated net savings between $200 and $300 per aligned beneficiary, with only the BASIC A and ENHANCED tracks falling outside this range with $185 and $130, respectively. In contrast, Track 1+ is the only Legacy MSSP track with a net savings per beneficiary over $100, with other Legacy tracks ranging from $14 to $89 – less than half the average savings of a Pathways track. Although BASIC C was the track with the highest per-beneficiary net savings at $296, BASIC E had the highest net savings per ACO at $5.8 million.

TABLE 4: PY2021 ACOS IN LEGACY MSSP TRACKS

	TRACK 1	TRACK 1+	TRACK 2	TRACK 3
Number of Participating ACOs	119	17	2	5
Number of Aligned Beneficiaries	2,654,291	397,480	69,534	130,638
Average Quality Score	89.72%	89.90%	89.10%	91.82%
ACOs that Generated Savings	81 (68%)	15 (88%)	1 (50%)	4 (80%)
ACOs that Earned Shared Savings	53 (45%)	11 (65%)	1 (50%)	2 (40%)
ACOs Owing Shared Losses	N/A	0 (0%)	0 (0%)	0 (0%)
Gross Savings	$552,548,566	$133,288,355	$5,723,973	$23,731,907
Bonus Payouts	$353,563,154	$67,268,019	$4,766,689	$12,060,872
Net Savings/Losses	$198,985,412	$66,020,336	$957,284	$11,671,035
Net Savings/Losses Per Aligned Beneficiary	$75	$166	$14	$89

TABLE 5: PY2021 ACOS IN PATHWAYS MSSP TRACKS

	LEVEL A	LEVEL B	LEVEL C	LEVEL D	LEVEL E	ENHANCED
Number of Participating ACOs	18	143	30	1	69	71
Number of Aligned Beneficiaries	446,114	2,587,566	355,201	20,085	1,531,623	1,931,793
Average Quality Score	88.70%	87.75%	89.98%	84.93%	93.03%	92.30%
ACOs that Generated Savings	13 (72%)	118 (83%)	25 (83%)	1 (100%)	64 (93%)	63 (89%)
ACOs that Earned Shared Savings	9 (50%)	68 (48%)	24 (80%)	1 (100%)	52 (75%)	53 (75%)
ACOs Owing Shared Losses	N/A	N/A	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Gross Savings	$128,658,814	$837,832,034	$211,384,874	$9,190,932	$777,096,334	$938,883,312
Bonus Payouts	$45,909,125	$300,935,341	$106,184,958	$4,503,557	$377,170,861	$687,070,907
Net Savings/Losses	$82,749,689	$536,896,693	$105,199,916	$4,687,375	$399,925,473	$251,812,405
Net Savings/Losses Per Aligned Beneficiary	$185	$207	$296	$233	$261	$130

TABLE 6: CHANGE IN THE NUMBER OF ACOS AND ALIGNED BENEFICIARIES IN EACH TRACK BETWEEN PY2020 AND PY2021

	Legacy MSSP Tracks				Pathways MSSP Tracks					
	TRACK 1	TRACK 1+	TRACK 2	TRACK 3	LEVEL A	LEVEL B	LEVEL C	LEVEL D	LEVEL E	ENHANCED
Participating ACOs	-14	-2	No change	No change	-36	+7	+10	No change	No change	-3
Aligned Beneficiaries	-190k	-67k	-11k	+0.6k	-500k	+1k	+111k	+5k	+174k	-14k
	Less Risk → More Risk				Less Risk → More Risk					

Despite falling eight percentage points from the prior year (making 2021 the lowest MSSP average quality score since 2014), overall quality scores for ACO participants remains strong, with 2021 ACOs still returning an average quality score of 90%. While both Legacy and Pathways ACOs averaged a 90% quality score, those bearing downside risk had a higher average quality score (92%) compared with upside-only ACOs (89%). Despite the PHE flexibility granting MSSP ACOs the option to remain in their same PY2020 track, many ACOs elected to advance to greater levels of risk in 2021 (Table 6). Legacy MSSP tracks saw several dropouts at the lower levels of risk and no risk track advancements, along with a net decline in assigned beneficiaries. Pathways tracks saw a sharp decline in Level A participation and an increase in Levels B and C. These tracks also saw a net decline in assigned beneficiaries, but the magnitude of the drop was smaller than in Legacy tracks.

This progress toward ACOs assuming financial accountability for their cost and quality outcomes is encouraging, not only for the future of the MSSP, but also for the Biden-Harris administration's aim to have all Medicare and Medicaid beneficiaries in an accountable care relationship by 2030.

PERFORMANCE BY PROVIDER TYPE

For the fourth year in a row, ACOs of all provider type categories (i.e., physician group-led, hospital-led, and those co-led by both) averaged net savings per beneficiary. In line with past trends, ACOs led by physician groups (45% of ACOs) realized the most savings, followed by ACOs co-led by collaborations between physician groups and hospital systems (28% of ACOs). The remaining ACOs, led by hospitals (27% of ACOs), had the lowest level of savings. Physician group-led ACOs and those led by both physicians and health systems increased their per-beneficiary savings, while hospital-led ACOs saw a decline in savings, meaning these ACOs alone were the reason for the overall decline in savings.

TABLE 7: NET PER BENEFICIARY SAVINGS BY ACO PROVIDER TYPE

ACO Provider Type	2021 Results	2020 Results
Physician Group-Led	$224	$218
Hospital System-Led	$147	$168
Both	$156	$145

When looking specifically at the provider makeup of ACOs, CMS noted that ACOs with more than 75% of physicians working as primary care physicians had net savings of $281 per beneficiary, while ACOs below this threshold only achieved net savings of $149 per beneficiary.

PERFORMANCE BY REVENUE DESIGNATION

In 2021, the number of ACOs in each revenue designation were roughly even, with 230 high-revenue ACOs and 245 low-revenue ACOs. However, high-revenue ACOs covered over 2 million more beneficiaries than low-revenue ACOs. Despite their larger size, results continue to demonstrate that low-revenue ACOs generate more savings than high-revenue ACOs while maintaining similar quality scores. In 2021, low-revenue ACOs generated a net savings of $243 per beneficiary, while high-revenue

ACOs generated only $122 per beneficiary. An impressive 84% of low-revenue ACOs generated savings and 69% earned shared savings bonus payments, compared to 77% and 46%, respectively, for high-revenue ACOs. One reason for the overperformance of low-revenue ACOs is that physician group-led ACOs are more likely to fall under this designation. Given that these ACOs generate, on average, higher savings, the same savings pattern emerges.

PERFORMANCE BY ACO SIZE

Generated per-beneficiary savings was strongly correlated with the size of the ACO, as measured by the number of assigned beneficiaries, with smaller ACOs generating higher savings. The top 40% of ACOs by size, which ranged from 15,866 to 220,365 beneficiaries, generated an average net savings of $145 per beneficiary; the bottom 60% of ACOs, which ranged from 3,014 to 15,859 beneficiaries, generated an average net savings of $211 per beneficiary – 47% higher.

PERFORMANCE BY STATE

When measuring performance by ACO state footprints, there were few clear geographic patterns. Many of the lower performers were found in the Midwest, including the lowest performer (South Dakota, which was the only state with a negative savings rate) and third lowest (Kansas, with savings of only 0.5%). Alaska, with savings of 0.2%, rounded out the bottom three performers. The top performers – Louisiana (6.5%), West Virginia (6.1%), and Washington (6%) – represent a wide diversity of geographies. (Figure 3)

TABLE 8: NET SAVINGS PER BENEFICIARY BY ACO SIZE

Size Percentile	Range of Assigned Beneficiaries	Average Net Savings Per Beneficiary
Largest 20% of ACOs	30,877 – 220,365	$139
60th – 80th percentile	15,866 – 30,795	$151
Middle 20% of ACOs	10,666 – 15,859	$214
20th – 40th percentile	7,711 – 10,619	$206
Smallest 20% of ACOs	3,014 – 7,664	$213

Figure 3: Shared Savings Rates by State

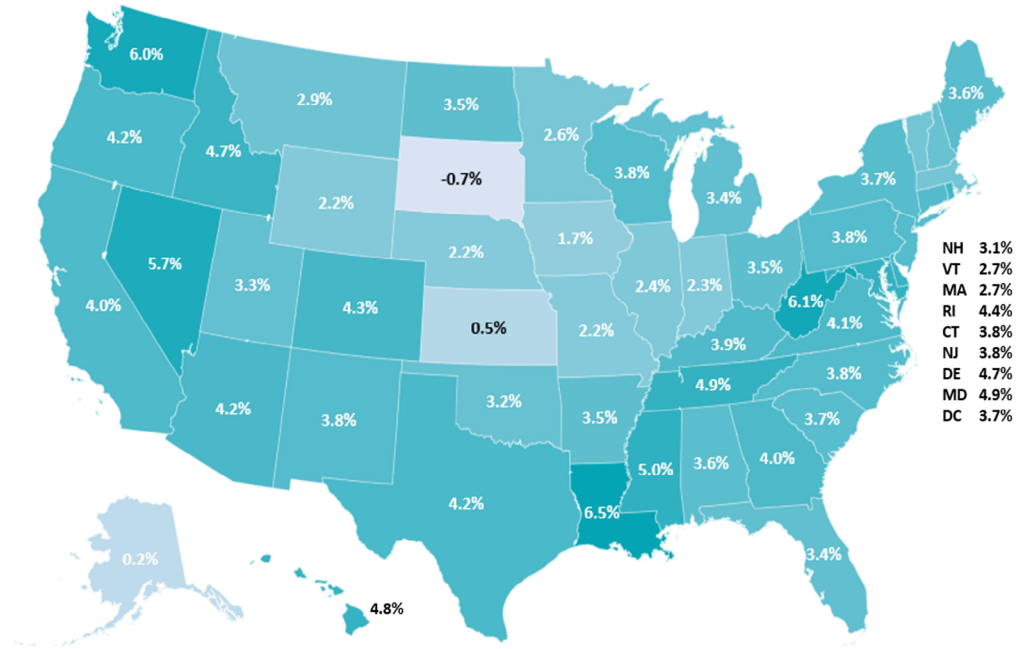
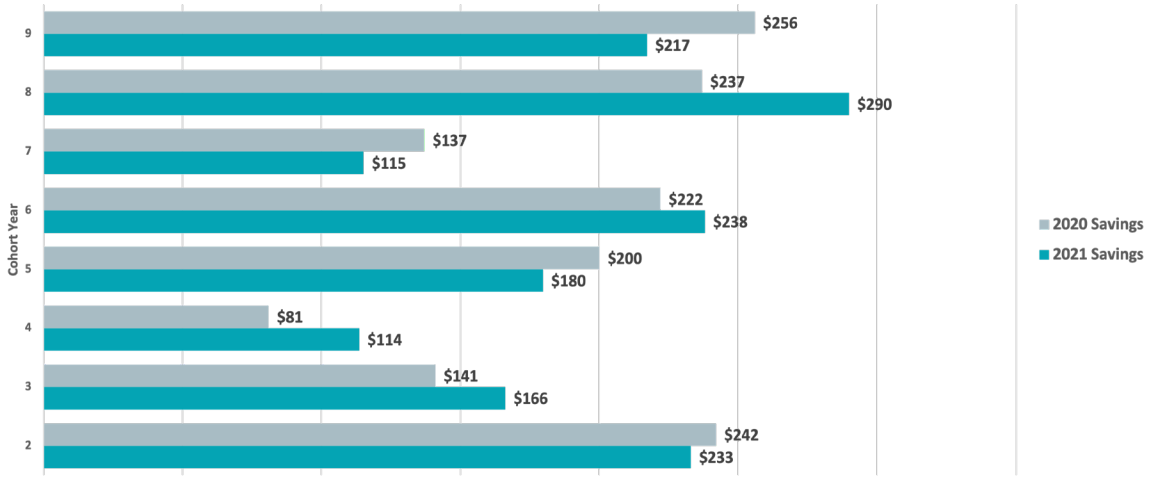


Figure 4: Net Savings Per Beneficiary by Cohort Year (Years in the MSSP)



*No Year 1 cohort for PY2021 since CMS did not allow new entrants
*ACOs in the 9-year cohort include those with start dates in April and July of 2012 and January of 2013

PERFORMANCE BY PROGRAM EXPERIENCE

Historically, the longer an ACO was in the MSSP, the greater the likelihood of generating savings. Recently, however, that trend has been less clear. Figure 4 shows the net savings generated per beneficiary by cohort year, which translates to program experience. Rather than observing net savings increase over time, there are three savings "peaks," but no observable trend towards greater savings over time.

One likely reason for the loss of this trend is that the makeup of ACO cohorts has changed over time. Figure 5 illustrates that hospital-led ACOs made up a greater share of total MSSP ACOs early in the program, but their share has declined in subsequent cohorts. Physician group-led ACOs and ACOs led by both physician groups and hospitals have grown to play a larger role in the MSSP, a well-established phenomenon. When the entity types (i.e., physician group-led, hospital-led, and both) are examined individually, the pattern of increasing savings over time re-emerges for physician-led ACOs and ACOs led by both physician groups and hospital systems. However, hospital-led ACOs trend in the opposite direction, with savings actually decreasing over time. When aggregating these different trends into one view, it implies no effect of program experience on savings.

Figure 5: Trends in ACO Provider Type

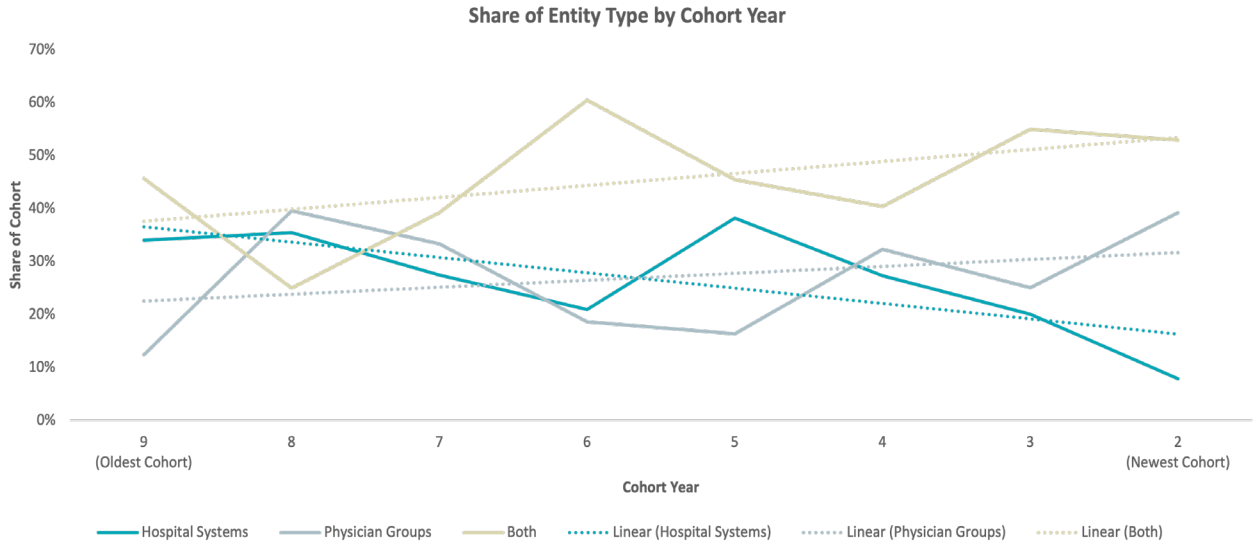
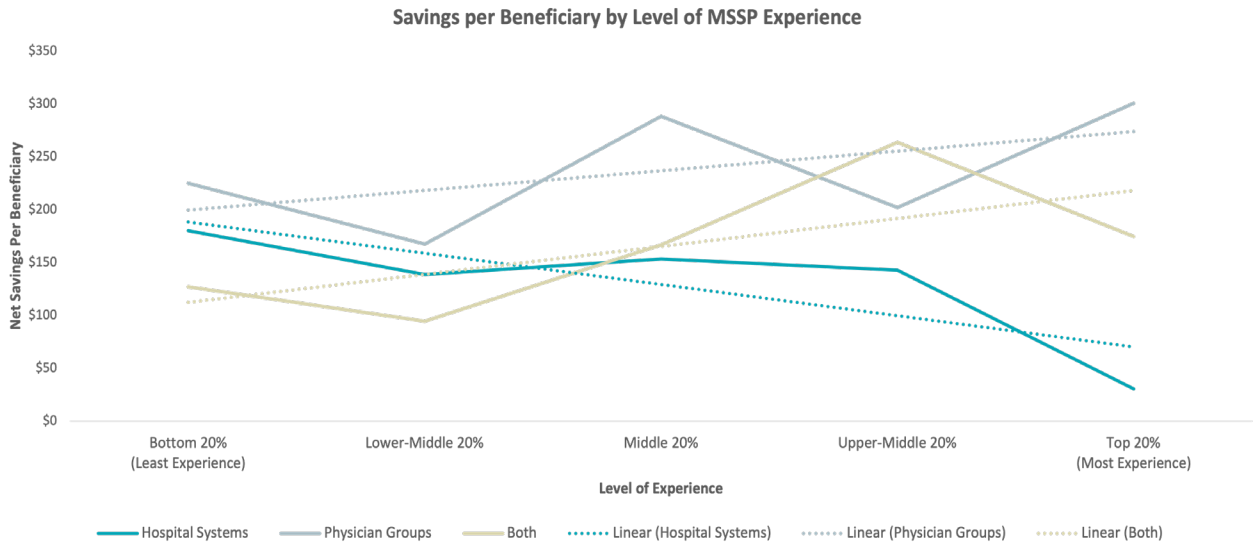


Figure 6: Trends in Net Savings by Level of Experience



Implications

The MSSP has played a critical role in the movement to value, as CMS' largest vehicle for advancing the adoption of accountable care. Since the program's start in 2012, the MSSP has reached more beneficiaries and providers than any other voluntary, total cost of care alternative payment model (APM). While the program has always been key to Medicare's value strategy, the 2021 performance results come at an important time for the MSSP and the broader value movement. The sections below discuss reactions from industry stakeholders in response to the latest performance data and consider potential implications for the future of the program.

INDUSTRY RESPONSE

The 2021 MSSP performance results come on the heels of a proposed rule including some of the most significant changes to the program since its inception, and in advance of the start of CMMI's more advanced accountable care model, ACO REACH. The proposed MSSP updates and new ACO REACH model represent bright spots in the ACO movement, following several years of plateaued growth and uncertainty surrounding the fate of the Next Generation ACO (NGACO) and GPDC models.

The strong 2021 MSSP performance results have been met positively by CMS officials, ACO leaders, and industry researchers expressing optimism for the future of the program and the broader value movement. Leaders at CMS called attention to the continued success of the program, with five years of consecutive net savings, and the recently proposed changes which aim to reinvigorate the program and bring in new ACOs to help realize the agency's goal of bringing all Medicare beneficiaries into an accountable care relationship by 2030. Other industry organizations reacted similarly and expressed their view that the MSSP will continue to be the primary driver of Medicare's value transformation.

Many organizations involved in sponsoring or supporting multiple MSSP ACOs are touting the strong performance of their ACO partners, like Aledade, Signify, and Privia, whose ACOs collectively represented a whopping $484 million in net savings in 2021. Farzad Mostashari, CEO and co-founder of Aledade, which had four of the top 10 performance ACOs in 2021 said, "CMS' announcement shows that the MSSP is strong, resilient, and delivering results for patients, doctors, and the entire nation." (See Appendices A & B for details on the top 10 performers)

> *"The Medicare Shared Savings Program is the foremost payment model driving value-based care. It must endure, it must grow, and it must be enhanced. We have an imperative to advance health value, and the continued positive trajectory of MSSP Performance Results shows us that this program is the largest and most effective means of accomplishing that objective. With Medicare insolvency looming, the MSSP provides an important lever to reshape healthcare delivery for improved population health equity at a much more affordable and sustainable spending level."*
>
> - Dr. Eric Weaver, DHA, MHA, Executive Director, Institute for Advancing Health Value

CONSIDERATIONS FOR THE FUTURE OF THE MSSP

While the MSSP was not always an apparent success, the program has produced net savings to Medicare for the last five consecutive years. While the total program savings - nearly $5.4 billion over the model's lifetime - are meaningful, the MSSP plays an even larger, indirect role in the value movement. According to Leavitt Partners research, the MSSP is a common starting point for many ACOs who decide to participate in an upside-only track of the MSSP as their first foray into value-based contracting. The MSSP has long served as a gateway into value, as a large, proven, standardized, and relatively safe model.

Understanding the important role of the program, CMS aims to preserve and expand its reach. The sections below share a high-level overview of the recently proposed changes, as well as additional requests from the industry.

The Impact of the Proposed Updates

While the strong performance seen in the 2021 results is a positive sign for the MSSP, the program is experiencing tepid growth (PY2022 will only see a net increase of eight ACOs, rising from 475 to 483), which advocates hoped would be a wake-up call to CMS. It clearly was, as in July 2022, the agency released a significant overhaul to the program as part of the Medicare Physician Fee Schedule proposed rule. The changes represent a reversion of the Pathways mentality under which CMS prioritized performance over participation. Now, CMS is working to attract new ACOs who may have avoided participation under the Pathways framework. The proposals aim to increase the attractiveness of the program using several levers, including:

- Slowing the transition to risk
- Remedying overly punishing benchmarking methodologies
- Incorporating health equity considerations
- Reducing administrative burden
- Adjusting quality measurement methodology

These changes represent a clear indication that CMS views the MSSP as a mainstay and driver of the value movement.

The Proposed Rule updates to the MSSP will certainly not be the end of changes to the MSSP. While the upcoming changes were responsive to stakeholder concerns about the program, there are still outstanding concerns not addressed and calls for further evolution of the MSSP. The Value in Health Care Act, initially proposed in 2021 with no action since, had some of its concerns addressed in the Proposed Rule updates, including advance payments and more focus on health equity and health disparities; other parts of the legislation, though, like the elimination of revenue designations and changes to shared savings rates for certain tracks, were not. Industry stakeholders also continue to call for MSSP tracks that step beyond the fee-for-service chassis, like partial capitation and the incorporation of NGACO model elements. How far these calls go remains to be seen.

Calls for Additional Changes

- **Removal of the ACO Revenue Designation**. When CMS introduced revenue designations as part of the Pathways overhaul, the agency intended to grant smaller, low-revenue ACOs additional flexibility in the timing of their glidepath to downside risk, viewing these groups as less equipped to take on significant financial risk, relative to their high-revenue counterparts. However, critics argue that using revenue to determine which ACOs are ready to take on risk may not be the best method, calling instead for a more accurate determination using variables like the demographics of the beneficiary

population. In fact, some industry stakeholders are calling for the elimination of the revenue designation altogether in light of the additional benefits to be assigned by revenue designation under the proposed 2023 MSSP overhaul (e.g., advance payments). They argue that the revenue distinction often puts ACOs with community health centers, rural health clinics, and critical access hospitals in the high-revenue designation, meaning they would not benefit from the revised policies they ostensibly target.

- **Reinstatement of the 5% Advanced APM Bonus.** The 5% bonus payment for providers participating in Advanced APMs, initially established in 2015 under the Medicare Access and CHIP Reauthorization Act (MACRA), is set to expire at the end of 2022. For ACOs in downside risk tracks, this represents a significant loss which could change the calculus around participation in higher risk tracks. The majority (78%) of attendees at a recent NAACOS conference indicated that the loss of the bonus would harm their organizations. While there would still be incentive to participate in Advanced APMs in the form of a higher annual update to the fee schedule (0.75% vs 0.25%), the strength of the incentive is greatly weakened. The Value in Health Care Act, if passed, would extend that bonus, and CMS Administrator Chiquita Brooks-LaSure has expressed the Biden administration's support for continuing the bonus payment, noting that its revival is in the hands of Congress and would be included in the upcoming budget proposal.

- **Continued Flexibility in Dealing with the Fallout from COVID-19.** While the impact of COVID-19 continues to wane, the PHE declaration and the changes and flexibilities it brought (see Appendix C) to the MSSP remains in effect, with another extension expected in mid-October that would extend the PHE until January 2023. While the healthcare sector's recovery from COVID-19 is underway, many are still struggling to deal with the fallout. Hospital systems in particular are facing significant financial strain, likely contributing to the reduced MSSP savings seen only in hospital-led ACOs. While costs associated with inpatient treatment for COVID-19 were removed from benchmarking, the downstream effects (e.g., the health debt accumulated from delayed preventive care, increased labor costs) will persist, affecting not just hospital systems, but other healthcare entities as well.

The continuation of the PHE means there will still be some relief in the near future, including a full reduction in shared losses for PY2022 and at least some relief through whatever portion of PY2023 falls during the PHE. ACOs will also be given one more year to remain in their current track before automatic advancement in PY2023. Expect calls for continued flexibilities and acknowledgement of the impact COVID-19 had and continues to have on the healthcare system.

There has been much discussion about the fate of the ACO movement in recent years, with proponents of accountable care calling on CMS and Congress to help kickstart stalled ACO growth, largely focused on the MSSP as Medicare's permanent ACO model. The proposals included in the 2023 PFS reflect CMS' answer to these calls. The proposed updates to the MSSP are just one important piece of Medicare's value-based care strategy, which includes efforts to align key aspects of value-based arrangements across CMS models and programs to set the stage for broader synchronization, encourage growth of accountable care models among primary care providers and specialists, and advance health equity through multiple mechanisms.

The Institute will continue to monitor CMS' efforts to advance health value, seeking opportunities to drive the broader industry toward high-quality, affordable, equitable care.

APPENDIX A: TOP 10 PERFORMERS (SAVINGS PER ALIGNED BENEFICIARY)

	Palm Beach Accountable Care Organization	Baylor Scott & White Quality Alliance	Privia Quality Network, LLC	Caravan Health Collaborative ACO	Steward National Care Network, Inc.	Advocate Physician Partners Accountable Care, Inc.	USMM Accountable Care Partners, LLC	Keystone ACO	Banner Health Network	Mercy Health Select, LLC
2021 Ranking	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**#8**	**#9**	**#10**
2020 Ranking	#1	#3	#5	Not in Top 10	#2	#7	Not in Top 10	Not in Top 10	Not in Top 10	#9
Track	ENHANCED	BASIC E	ENHANCED	Track 1	ENHANCED	BASIC E	ENHANCED	BASIC E	ENHANCED	ENHANCED
Provider Type	Physician Group	Hospital System	Physician Group	Physician Group	Hospital System	Both	Physician Group	Both	Hospital System	Both
Revenue Designation	Low-revenue	High-revenue	Low-revenue	High-revenue	High-revenue	High-revenue	Low-revenue	High-revenue	Low-revenue	High-revenue
Years in MSSP	10.2	7.7	8.7	4.7	4.7	10.2	7.7	9.7	5.7	10.2
Quality Score	100	98.48	95.73	89.05	88.79	89	63.4	92.05	98.93	93.15
Total Benchmark Minus Expenditures	$84,231,357	$124,593,794	$56,655,800	$72,145,002	$46,925,491	$56,906,719	$35,120,362	$52,308,657	$34,803,680	$34,550,124
Total Shared Savings Paid	$61,910,047	$61,050,959	$41,642,013	$35,351,051	$34,490,236	$27,884,292	$25,813,466	$25,631,242	$25,580,705	$25,394,341
Net Savings	$22,321,310	$63,542,835	$15,013,787	$36,793,951	$12,435,255	$29,022,427	$9,306,896	$26,677,415	$9,222,975	$9,155,783
Aligned Beneficiaries	89, 403	125,258	64,175	220,365	148,277	98,212	13,885	69,246	68,075	60,671
Net Savings Per Aligned Beneficiary	$249.67	$507.30	$233.95	$166.97	$83.87	$295.51	$670.28	$385.26	$135.48	$150.91

APPENDIX B: TOP 10 PERFORMERS (TOTAL SHARED SAVINGS PAID)

	Allcare Options, LLC	Bluestone ACO	360 ACO	Primary PartnerCare ACO Independent Practice Association, Inc.	Orange Accountable Care of New York	Asian American Accountable Care Organization, LLC	The Premier HealthCare Network LLC	LTC ACO	Physicians ACO, LLC	ACO Clinical Partners, LLC
Track	BASIC C	BASIC B	BASIC B	BASIC B	Track 1	BASIC E	BASIC B	ENHANCED	Track 1	BASIC B
Provider Type	Physician Group	Physician Group	Physician Group	Physician Group	Physician Group	Physician Group	Physician Group	Physician Group	Physician Group	Physician Group
Revenue Designation	Low-revenue	Low-revenue	Low-revenue	Low-revenue	Low-revenue	Low-revenue	Low-revenue	Low-revenue	Low-revenue	Low-revenue
Years in MSSP	10.2	2.7	2.7	8.7	7.7	10.2	9.7	6.7	7.7	3.2
Quality Score	83.47	77.91	81.66	100	97.32	98.32	61.69	79.53	97.5	99.02
Total Benchmark Minus Expenditures	43,351,432	18,227,480	7,376,870	13,288,730	20,899,266	15,187,068	5,421,657	28,075,166	12,869,650	23,184,610
Total Shared Savings Paid	21,242,202	7,145,172	2,891,733	5,209,182	10,240,640	7,441,664	2,125,290	20,635,247	6,306,129	9,088,367
Net Savings	22,109,230	11,082,308	4,485,137	8,079,548	10,658,626	7,745,404	3,296,367	7,439,919	6,563,521	14,096,243
Aligned Beneficiaries	13,281	7,068	3,956	7,711	10,715	7,792	3,357	8,018	7,269	17,809
Net Savings Per Aligned Beneficiary	$1,664.73	$1,567.96	$1,133.76	$1,047.80	$994.74	$994.02	$981.94	$927.90	$902.95	$791.52

APPENDIX C: SELECT COVID-RELATED CHANGES TO THE MSSP

- **CMS extended the timeframe covered under the Extreme & Uncontrollable Circumstances policy, protecting all ACOs from shared losses generated in 2021.**
  CMS utilized the program's Extreme & Uncontrollable Circumstances policy to waive all shared losses for the period of the COVID-19 Public Health Emergency (PHE).

- **CMS removed costs associated with COVID-19 inpatient treatment from benchmarking.**
  To prevent ACOs from being unfairly rewarded or penalized for having higher or lower incidence of COVID-19 in their communities, CMS adjusted the MSSP methodology to exclude COVID-19 claims expenditures—triggered by inpatient admission and the subsequent month—from performance and benchmarking, completely excluding the affected months from per capita expenditure calculations.

- **CMS granted ACOs the option to remain in their current track and benchmark for PY2021 and PY2022.**
  For ACOs whose participation periods were set to expire at the end of 2020, CMS provided the option to extend under their current track and benchmark for one additional year, including Track 1 ACOs that would have otherwise had to move to a Pathways to Success track.

- **CMS expanded the definition of primary care services used for determining beneficiary assignment in 2021.**
  To address concerns regarding attribution due to the large drops in in-person primary care visits, CMS expanded the definition of "primary care services" for determining beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication.

- **CMS granted ACOs the higher of their earned MIPS quality performance category score or the 30th percentile score, ensuring ACOs met the minimum quality performance standard to participate in shared savings for FY2021.**
  CMS utilized the program's Extreme & Uncontrollable Circumstances policy to grant every ACO able to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP) and meet MIPS data completeness and case minimum requirements the higher of their earned MIPS quality performance category score or the 30th percentile MIPS quality performance category score for 2021.

About the Institute

The Institute for Advancing Health Value (the Institute) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the Institute serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the Institute, visit advancinghealthvalue.org. The Institute is formerly known as the Accountable Care Learning Collaborative (ACLC).