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Why Do Accountable Care Organizations Leave The Medicare Shared Savings Program?

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ABSTRACT The ability of accountable care organizations (ACOs) to continue reducing costs and improving quality depends on understanding what affects their survival. We examined such factors for survival in the Medicare Shared Savings Program (MSSP) of 624 ACOs between performance years 2013 and 2017 (1,849 ACO-years). Overall, ACO exits from the MSSP decreased after ACOs' third year. Shared-savings bonus payment achievement, more care coordination, higher financial performance benchmarks, market-level Medicare cost growth, lower-risk patients, and contracts with upside-only risk were associated with longer survival. Quality scores, postacute care spending, organizational traits, and most market-context characteristics had no significant association with survival, which indicates that diverse organizations and markets can be successful. Put in context with the recently finalized MSSP rule from December 2018, our findings suggest that while new flexibilities for low-revenue ACOs likely reduce uncertainty for some, MSSP ACOs may need more than the new period of one to three years to prepare for downside risk. Policy makers should offer more support to ACOs (especially those with higher-risk patients) for building organizational competencies and should consider how benchmarking policy can fairly assess ACOs from regions with differing levels of cost growth.

Accountable care organizations (ACOs) are a key strategy for reforming health care delivery by giving providers greater financial and quality accountability for a patient population.^{1–4} According to the most recent estimates, ACOs are widespread: There are 1,011 of them, covering over thirty-two million lives.⁵ Medicare's flagship ACO program, the Medicare Shared Savings Program (MSSP),⁶ has grown steadily over time and is Medicare's largest ACO program.⁷

Overall, the MSSP has reduced spending and improved quality compared to fee-for-service Medicare.^{8,9} The academic literature has elucidated further findings and potential mecha-

nisms. For example, the ACO model, compared to non-ACOs, is associated with reduced post-acute care and skilled nursing facility stays,¹⁰ reduced readmissions,¹¹ and improved patient experience.¹² Studies of potential mechanisms suggest that among MSSP participants, achievement of shared-savings bonus payments is associated with shifting spending from inpatient and skilled nursing facility settings to physician office settings,¹³ and improved quality scores are associated with reductions in postacute care expenditures.¹⁴

A number of policy issues affect an organization's decision to begin or continue participating in an ACO. One issue is the timing of moving MSSP ACOs into downside risk.¹⁵ As 2018 began,

the first cohort of MSSP ACOs—those that joined in performance year 2013—were beginning their sixth year (that is, the final year of their second three-year agreement period) and were thus scheduled for mandatory downside risk beginning in 2019. Several ACO organizations advocated for an additional third period of upside-only risk.¹⁶

Another key issue relates to financial performance benchmarking policy: There is debate over historical versus regional benchmarking (with regional expenditures integrated into the benchmark after the first agreement period). ACO leaders and experts differ on the benefits and drawbacks of each method.^{17–20}

In August 2018 the Centers for Medicare and Medicaid Services (CMS) released a proposed rule to overhaul the MSSP,²¹ including more quickly shifting ACOs to downside risk (especially for “high-revenue” ACOs, which tend to be hospital-led) and increasingly shifting toward region-based benchmarking. CMS released the final rule in December 2018.²² After considering comments, the agency ultimately kept many proposed provisions, including the accelerated risk time frame, but it did increase some flexibility for “low-revenue” ACOs (primarily resource-constrained physician-led ACOs and rural hospital-led ACOs), especially if their beneficiaries and physicians were new to advanced payment models.²²

ACO leaders have flagged these issues and others—such as quality measurement, risk adjustment, organizational competencies, and market context—as affecting whether they continue to participate in ACO models. ACO leaders might ponder what is within their control to adjust to maximize their experience in the program. CMS, in turn, has an interest in what types of ACOs are leaving the program and what factors influence exit, given recent analyses suggesting that MSSP ACOs improve over time.^{9,23}

While there is some research on market and demographic factors associated with ACO formation,^{24,25} almost nothing is known about what influences ACO survival. Prior evidence on hospital survival^{26–28} suggests that ACOs may succeed if they adapt to changes in resources and their contexts. However, generalizability to ACOs is unclear, given that ACOs and hospitals differ substantially in terms of how care is paid for, how risk is assumed, and how providers interact within and across organizations to care for patients. To our knowledge, only one study, looking at the Pioneer ACO program, has examined the relationship between financial performance and ACO withdrawal after the first year, and it found no differences in savings between ACOs that stayed and those that left.²³ The self-

selection bias among “pioneers” (early joiners of a voluntary ACO program, which may be more prepared to succeed), the lack of adjustment for ACO characteristics when examining program withdrawal, and the use of only one year of data limit the generalizability of the study’s results to other ACO programs, however.

Some ACO exits might not necessarily be bad—if the ACOs were not committed to change, for example. Nonetheless, given the increasing prevalence of ACOs in the United States, CMS, policy makers, and current or prospective ACOs would benefit from understanding what affects ACO survival in the MSSP,¹³ to maximize resources and program success and ultimately improve health care value. Based on the limited evidence and theory available, we hypothesized that ACOs might survive longer if they had higher quality scores; achieved shared-savings bonus payments; and had higher financial performance benchmarks, more care coordination or primary care resources, less spending on post-acute care, or locations in more expensive markets. The likely impact of other factors, such as the timing of downside risk, is unclear.

Using four linked data sources on a panel of ACOs during the first five years of the MSSP, we employed longitudinal survival analysis methods to assess how a comprehensive set of empirically motivated factors was associated with length of program participation.

Study Data And Methods

STUDY POPULATION The study population was ACOs participating in the Medicare Shared Savings Program at any point in the first five performance years. In the first performance year (2013), CMS allowed ACOs to join April 1, 2012, July 1, 2012, or January 1, 2013. Every other performance year began January 1 of the given year. There were 220 ACOs in performance year 2013, 333 in 2014, 392 in 2015, 432 in 2016, and 472 in 2017—altogether, 624 unique ACOs that collectively represent 1,849 ACO-years.

DATA SOURCES We merged four data sources: The first was all publicly available MSSP ACO data (financial performance and quality scores of and descriptive data on ACOs, their beneficiaries, and their providers).^{29–32} The second was data from the Leavitt Partners ACO Database, also known as Torch Insight, which contained information on ACO taxonomy and risk-bearing arrangements.^{33–37} The third was CMS’s Medicare Geographic Variation Public Use File,³⁸ which provided information on market-context variables. The last, used for a subanalysis, was data from the 2017 Annual ACO Survey (developed by Leavitt Partners and the National Association of

ACOs) about care coordination, health management, and health information technology (IT) competencies.^{39,40} The Annual ACO Survey was fielded in the period January–April 2017, and while only about a quarter of all ACOs responded to it, they were similar to nonresponders in terms of contract type, size, taxonomy, CMS program participation, and region.⁴⁰ See online appendix exhibit 1 for more information on the survey questions.⁴¹

ANALYTIC METHODS The outcome was length of time (in years) that an ACO remained in the MSSP from time of entry to time of exit or censure on January 1, 2018. The constructed panel contained key information from the sources listed above on ACO performance, financials, organizational traits, beneficiary health, competencies, and market context that had been discussed or hypothesized in the literature as important to ACO success.

As the outcome was time to event, this study used survival analysis methodology. We used multivariate parametric, random-effects survival regression, which is well developed, has been used in health policy research, and allows the use of time-varying data (which Cox regression does not) while still working within a proportional hazards model.^{42–44}

For the three competency variables from the Annual ACO Survey (care coordination, health management, and health IT competencies), we had survey responses from only 140 (22.4 percent) of the 624 ACOs. Accordingly, we included these variables in the analysis only when we estimated their coefficients. All other covariate coefficients were from models that did not contain the competency variables and thus represented the universe of 595 MSSP ACOs in the period from performance years 2013 to 2017 (or the 95.4 percent of all 624 ACOs that were not missing any covariates), which allowed us to maximize sample size and generalizability to all ACOs.

We explored and visualized significant results from these multivariate models using Kaplan-Meier survival curves, which were then summarized for selected time periods in figures. We conducted all analyses in Stata/SE, version 15.1.

One additional consideration factored into the analysis was whether an ACO left the program in the middle or at the end of a contract. An ACO's leaving in midcontract could indicate that the organization was unable to make adequate changes to achieve a shared-savings bonus payment and had decided to exit. An organization's leaving at the end of a contract could represent that, too, but it also could represent a well-functioning ACO that achieved bonus payments and exited for other reasons. Depending on the rea-

The most important programmatic factor for ACO survival appears to be an ACO's ability to realize bonus payments.

son, exits could be good or bad for the program. This analysis required splitting the outcome into two samples, which reduced power and generalizability. Thus, we performed a sensitivity analysis to examine the data in this way, and the findings are discussed in the “Study Results” section.

LIMITATIONS This study was subject to the following limitations, which we attempted to minimize. First, analyses were not causal, although newer survival methods exploited time-varying data, and using data from four sources allowed us to maximize available variation to examine the most comprehensive set of factors known or thought to relate to ACO success.

Second, ACOs that choose to be in the MSSP are not necessarily representative of all ACOs. However, the MSSP does represent the largest group of ACOs, which likely means that diverse providers participate.

Third, the timing of entry into the program could be indicative of survival ability if earlier joiners were more successful organizations. We could not use cohort as a covariate in survival regression: Cohort entry is mechanically related to maximum survival time, and the same factors that affect survival likely also affect entry, which could bias estimates via “bad control” bias.⁴⁵ A log-rank test for equality of survivor functions stratified by entry date, however, was not significant ($p = 0.86$), which reduced concern that this was an issue.

Fourth, while most measures were longitudinal, some were not. This limited their generalizability, although in these cases they were the only available data—which made them more valuable to include than not.

Last, the literature suggests that CMS's benchmarks and shared-savings calculations significantly underestimate spending reduction and net savings to Medicare.^{9,46} A key goal of this

study was to understand how ACOs use information provided to them by CMS to make business decisions about staying in the program and changing their practices. While better benchmarking and shared-savings calculations could be used in the program moving forward, and while we recognize that current methods are not ideal counterfactuals, ACOs use current benchmarks to make business decisions concerning whether to continue in the program.

Study Results

Of the 624 ACOs existing at any time in the first five years of the Medicare Shared Savings Program performance files, 187 (30 percent) exited the program at some point (59 percent of them exited midcontract, and 41 percent did so at the end of a contract). The rate of program exit by year was 2.7 percent in 2013, 9.0 percent in 2014, 15.3 percent in 2015, 13.0 percent in 2016, and 7.4 percent in 2017. Examined a different way, the rate of program exit was 4.0 percent for ACOs in their first year and 9.5 percent for second-year, 20.7 percent for third-year, 10.6 percent for fourth-year, and 11.2 percent for fifth-year ACOs. The overall Kaplan-Meier survival curve is shown in appendix exhibit 2.⁴¹ Note that risk of program exit by calendar year and years of experience peaked in year three and then generally decreased.

Six factors were significantly associated with risk of MSSP program exit. Four factors reduced the risk: ever achieving shared-savings bonus payments (hazard ratio: 0.22), having a higher benchmark per capita (per \$1,000 increase, HR: 0.80), being in a market with higher Medicare cost growth (per 1 percent increase, HR: 0.66), and offering more of the fourteen possible care coordination services (for each additional service offered, HR: 0.73) (exhibit 1). (The last hazard ratio refers only to the 22.4 percent of ACOs that responded to the Annual ACO Survey.) Two factors increased the risk: bearing downside risk (HR: 2.18) and having higher Hierarchical Condition Categories risk scores, which indicate sicker patients (per 10 percent increase, HR: 1.55).

For the shared-savings bonus payment finding, the results of sensitivity analyses presented in exhibit 1 showed that this result was still significant when we defined bonus payments in other ways: in the ACO's first program year, most recent program year, or any given year; or any savings, even if not high enough to trigger bonus payments.

To visualize significant findings, exhibits 2, 3, and 4 decompose key time points from Kaplan-Meier survival curves by ACO financials (achiev-

ing shared-savings bonus payments and accepting downside risk), highest and lowest quartiles of financial performance benchmarks and Hierarchical Condition Category patient risk scores, and quartiles of care coordination services of-

EXHIBIT 1

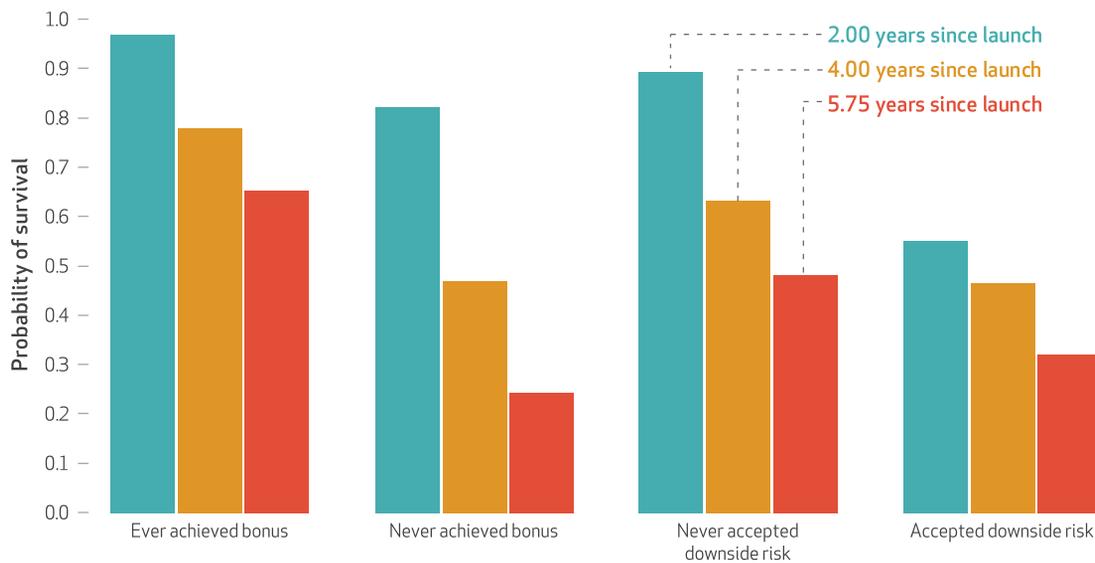
Association of selected variables with the risk that an accountable care organization (ACO) would exit the Medicare Shared Savings Program (MSSP)

Variable	Hazard ratio
MEDICARE SHARED SAVINGS PROGRAM PERFORMANCE	
Shared savings (ever)	0.22***
Savings or losses sensitivity analyses	
Shared savings (any given year) ^a	0.42****
Shared savings (first year in program) ^b	0.53**
Shared savings (most recent year in program) ^a	0.39***
Any savings (any given year) ^a	0.67**
Quality measures tracked for all 5 years ^b	0.95–1.03
FINANCIALS	
Per capita benchmark value (thousands)	0.80***
Postacute care expenditure (%)	1.02
Commercial ACO contract	0.65
Risk bearing: track 2 or 3 (ref: track 1) ^c	2.18**
ORGANIZATIONAL TRAITS	
Taxonomy (ref: provider-led)	
Hospital-led	0.67
Co-led	0.61
Ratio of patients to providers	1.00
Ratio of primary care providers to specialists	1.00
Size (per 1,000 lives)	1.00
BENEFICIARY HEALTH	
Hierarchical Condition Categories composite score ^d	1.55**
MARKET CONTEXT	
Rurality (% of rural covered lives)	1.00
Local to national Medicare cost ratio	0.20
Local to national Medicare cost growth ratio	0.66**
Local to national Medicare Advantage penetration ratio	0.64
Local to national inpatient days ratio	0.37
Local to national skilled nursing facility days ratio	1.01
ACCOUNTABLE CARE ORGANIZATION COMPETENCIES (NUMBER OFFERED)^e	
Care coordination services	0.73***
Health management services	1.07
Health information technology services or products	0.75

SOURCE Authors' analysis of data from the MSSP performance files, Leavitt Partners ACO Database, Medicare Geographic Variation Public Use File, and Leavitt Partners/National Association of ACOs Annual ACO Survey. **NOTES** The exhibit shows results from multivariate parametric random-effects survival regression. The full model contains the 595 (95.4 percent) MSSP ACOs not missing any covariates (except competency covariates, which has higher missingness) from performance years 2013 to 2017. Except where noted, coefficients were adjusted for "shared savings ever" (as opposed to the sensitivity analyses' varying ways to measure savings) and all other covariates in the table except the competency covariates, which have limited sample size. Thus, except where noted, coefficients represent the 595 ACOs not missing any covariates other than competency covariates. ^aCoefficients are from sensitivity analyses that examined different operationalizations of savings in the full model. ^bIncludes the nine MSSP quality measures that were used in all five years without significant measure specification changes and that had no multicollinearity concerns. To include 2017 measure specifications, we extended the findings of table 1 in Bleser WK, et al. ACO quality over time (see note 14 in text). No hazard ratios for quality measures in the main model were significant. ^cTrack 1 is upside risk only; tracks 2 and 3 are upside and downside risk. ^dPer 10% increase in population risk score. ^eResults from these coefficients contain data from only the 140 (22.4 percent) ACOs that responded to these questions in the Annual ACO Survey. ***p* < 0.05 ****p* < 0.01 *****p* < 0.001

EXHIBIT 2

Probability of accountable care organization (ACO) survival over time, by achievement of shared-savings bonuses and acceptance of risk for financial losses



SOURCE Authors' analysis of data from the Medicare Shared Savings Program performance files.

ferred, respectively.

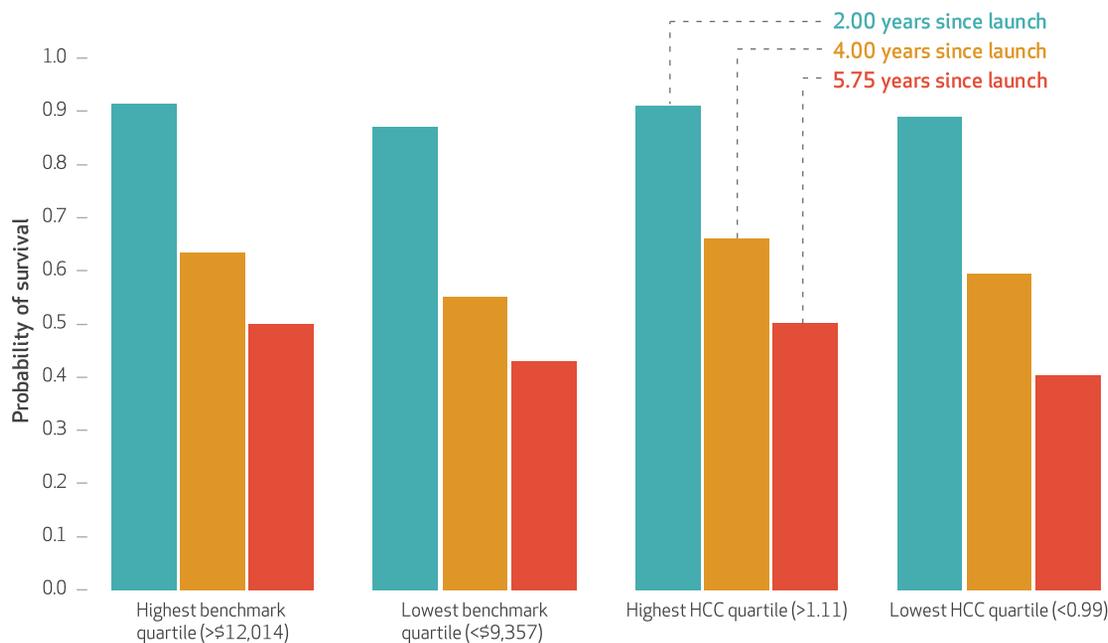
Several characteristics were notably not associated with survival. There was no significant relationship between an ACO's exiting the MSSP

and any quality measures, postacute care spending, any organizational trait, and five of the six market-context measures (exhibit 1).

Sensitivity analyses that reran all models for

EXHIBIT 3

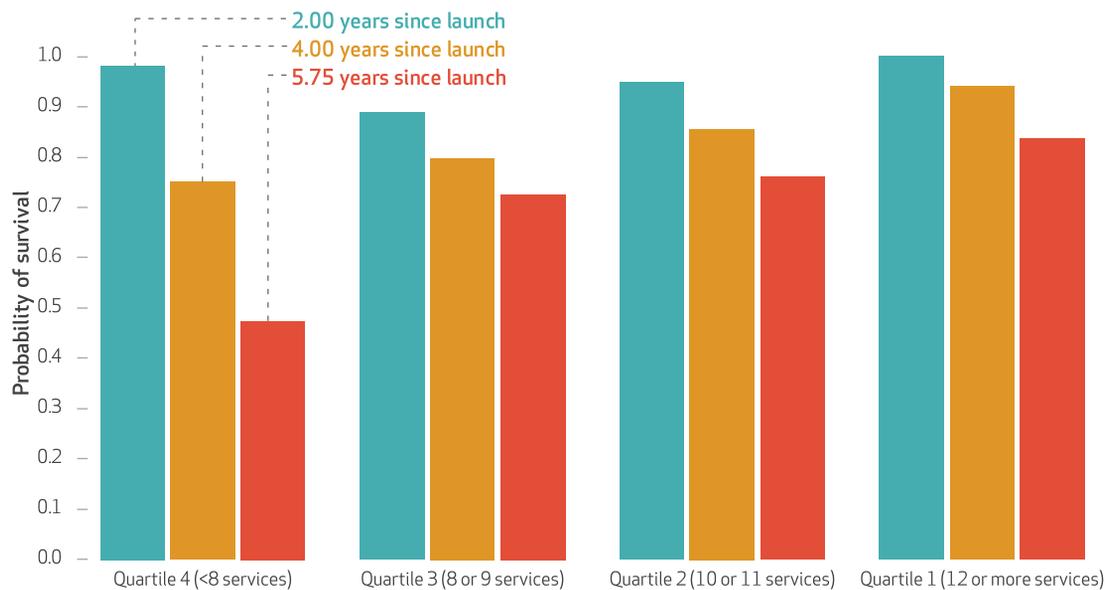
Probability of accountable care organization (ACO) survival over time, by quartiles of benchmark and Hierarchical Condition Categories (HCC)



SOURCE Authors' analysis of data from the Medicare Shared Savings Program performance files. NOTE Benchmarks are used to assess financial performance, and HCC is used to assess the health risk of ACOs' patient populations.

EXHIBIT 4

Probability of accountable care organization (ACO) survival over time, by quartile of care coordination services



SOURCE Authors' analysis of data from the Medicare Shared Savings Program performance files and the Leavitt Partners/National Association of ACOs Annual ACO Survey. **NOTE** The results show data for only the 140 (22.4 percent) ACOs that responded to the Annual ACO Survey.

ACOs leaving midcontract revealed significance levels identical to those in the full model but with coefficients of slightly larger magnitude (data shown in appendix exhibit 3).⁴¹ This indicates that compared to ACOs that left the MSSP at the end of a contract, those that left midcontract experienced similar patterns of hazard but were slightly more sensitive to changes in bonus payments, benchmarking, risk adjustment, downside risk, cost growth, and care coordination capabilities.

Discussion

The Medicare Shared Savings Program is the largest of all ACO programs, widespread, and growing. About 30 percent of ACOs in the program decided to exit at some point in its first five years. There is little to no evidence on how key ACO performance, traits, competencies, and contexts affect program survival. We investigated this research gap by linking four data sources and using improved survival methodology that could handle time-varying data. Our findings, while associative and lacking the ability to definitively assert causality, account for the most comprehensive set to date of empirically motivated factors and have major implications for CMS (especially with regard to the MSSP final rule),²² private payers that operate ACO programs, ACOs, and policy makers.

First, in terms of MSSP performance and financial variables, the program could benefit from adjustments to its key components. One issue about which there is much debate is the timing of moving MSSP ACOs into downside risk. Currently, CMS's policy is to allow an ACO to have two "agreement periods" (for a total of six years) in track 1 (upside risk only) before moving into tracks 2 or 3 (upside and downside risk). The first cohort of ACOs—which entered the program on or before January 1, 2013—reached the end of their second agreement period at the end of 2018, and ACO stakeholders recently argued to CMS that this was not enough time to prepare for downside risk, asking for a third track 1 agreement period.¹⁶ No MSSP ACOs were required to take on downside risk in the time period for which data were available (through 2017). Accordingly, while the number of ACOs that voluntarily entered downside-risk contracts is low, it is increasing (from 0.8 percent of ACOs in performance year 2013 to 8 percent in 2017). On the one hand, evidence suggests that the longer an ACO participates, the more willing it is to adopt two-sided risk.⁴⁰ This implies that there is a time frame according to which successful ACOs could comfortably move to downside risk and accelerate program savings. On the other hand, in our study we found that ACOs with downside risk had higher rates of exit. This raises the concern that the new MSSP rule²²—

which would allow an ACO only one to three years (less than two years in most cases) before moving to downside risk, substantially less than the current six years—could cause successful ACOs to drop out of the program.⁴⁷ We found in descriptive trends that ACO exit risk drops after the first three years, which could suggest that ACOs need at least three years to adjust to the program and start making changes in their practices to accept downside risk. This is not a causal claim, however, and further research is needed.

A second key program issue relates to prior concerns that high-performing organizations with low benchmarks or existing ACOs that made big improvements and dropped their benchmarks (that is, ACOs with little “fat to trim” in both cases) may be disadvantaged.^{17,19} We did observe this: Each \$1,000 decrease in per capita benchmark was associated with a 25 percent increased risk of program exit. It could be that efficient organizations have a harder time becoming even more efficient to achieve bonus payments, a correlation documented elsewhere.¹⁸ This type of exit would be a loss for the program and for patients. Regional benchmarking, which currently begins during the second three-year agreement period, provides opportunity for high-performing ACOs with lower benchmarks to achieve bonus payments, and this could make it easier for successful ACOs to stay successful. The MSSP final rule²² expedites this transition by having all ACOs begin with a proportion of their benchmark (increasing over time to 50 percent) adjusted regionally. This is likely a positive direction for the program,⁴⁸ but it will still require addressing regional cost trends.⁴⁷ (Moreover, we hear anecdotally from some ACOs that regionally adjusted benchmarks are a primary reason to stay in the program.) More research is needed on how to construct the ideal balance of historical and regional blended benchmarks—and how to include regional cost growth, which we found is related to program exit—to encourage continued improvement without penalizing success.

ACOs with higher Hierarchical Condition Categories medical risk scores (sicker patients) also had shorter survival in the MSSP. These risk scores are used to adjust payments back to the ACO. One existing concern is that the current Hierarchical Condition Categories risk-adjustment system does not adequately account for very sick or frail patients—that is, it underpays ACOs.⁴⁹ While the new rule still uses the same risk-score methodology, it does change how the risk scores are applied and updated in the program to address issues with changing risk scores and populations. Previously, an ACO’s new beneficiaries received individual risk scores at the

time they were first attributed to the ACO, and the ACO’s continuing beneficiaries’ risk scores were recalculated annually but changed only if the patient’s risk score decreased (the person became healthier). This was done to reduce the incentive for ACOs to document their patients’ conditions as more severe (to upcode), but it also meant that the ACO had a financial risk if its existing patient population became sicker between years. The final rule addresses these issues by allowing the risk score to increase if patients become sicker, limiting risk to providers, although it caps how much the risk score can change across the length of the agreement period.⁴⁸ CMS argues in the rule²² that the cap is set high enough to protect providers from being responsible if their patient populations are sicker than before, while not being too high (which could result in ACO upcoding). Further research is needed to determine whether other cap levels would be more appropriate (especially if upcoding becomes an issue). CMS could also consider providing additional support to ACOs with higher risk scores to prevent them from leaving the MSSP—or creating a modified ACO option for ACOs with a higher proportion of seriously ill patients. If this is not solved, these ACOs may leave the program.

A third program issue relates to finding no association between MSSP quality scores and program survival. Improvement in the quality of care is a main goal of accountable care. However, to date it has not tended to be a driving factor in ACO participation, as it plays a relatively minimal role in financial performance. In the most recent MSSP results, the average quality score for ACOs was about 91 percent, and there was no meaningful correlation between quality and financial performance—which is consistent with prior years.¹⁸ Some health system leaders have argued that the Triple Aim specifically seeks lowered cost through improved quality,⁵⁰ but the lack of correlation suggests that ACOs are addressing the two separately. The high average scores on many quality measures also suggest that quality is not a barrier to participation, as ACOs are able to consistently achieve high scores. CMS should consider heightened financial incentives tied to quality scores, higher minimum quality attainment levels, or higher thresholds for receipt of full bonus payments. However, this must be done thoughtfully to give ACOs an opportunity to improve if their quality scores are below average.

The most important programmatic factor for ACO survival appears to be an ACO’s ability to realize bonus payments. Even achieving a bonus just once cut the risk of program exit by more than three-quarters, which indicates that CMS

benchmarks and shared-savings bonus payment calculations are extremely important for an organization's business decision to participate or continue participating in ACO models (and this association is likely stronger in reality, because of shared savings' underestimating true savings).^{9,46} Perhaps once they "taste the prize," they believe they can do it again. This type of relationship with program longevity is likely a good thing for CMS because it indicates that ACOs will continue to stay in the program when they are saving money for Medicare—even if they may save more in reality than CMS's methods suggest. Accordingly, initiatives from CMS that help ACOs become more successful, such as sharing best practices to lower costs or increasing flexibility (such as the three-day skilled nursing facility waiver), could increase survival.

One important policy concern that CMS needs to address relates to our finding that ACO location in markets with increasing Medicare costs was associated with lower rates of exit. On an even playing field, the Medicare cost growth in an ACO's local market should not matter, as it would neither benefit nor detrimentally affect an ACO's performance, but the significant difference we found suggests that it does matter. While the new MSSP rule²² does increase the amount of regional benchmark assessment, additional work is needed to assess whether high-cost-growth markets are advantaged or low-cost-growth markets are disadvantaged, and CMS should critically evaluate how benchmarks are set and updated based on this work.

Finally, our findings relate to accountable care competencies, as longer survival was associated with ACOs' offering more care coordination services. This may reflect provider commitment, as organizations making significant investments in care coordination—a key mechanism of the ACO model—may be more likely to have made significant strategic decisions to focus on accountable care. These organizations may be committed for the longer term, as they want to see their investments pay off, and they may be more likely to see better financial outcomes because of concerted

efforts made to change the delivery of health care. Alternatively, ACOs that are "ACOs in name only"—that join the program but do not invest meaningful resources—may be more likely to drop out because they have nothing to lose from leaving. This may be one case where ACO exit is good. CMS must decide how best to assist ACOs in developing organizational competencies necessary for success.⁵¹

Conclusion

The ACO model is increasingly widespread, and the Medicare Shared Savings Program is the largest of all ACO models. While it is not necessarily the responsibility of CMS to keep all ACOs in the program, especially those not performing well, it is important to ensure that there are no systematic issues preventing ACOs from succeeding. Moreover, it is the responsibility of CMS to improve care delivery and lower costs, and recent analyses of the MSSP suggest that ACOs are doing both. While a variety of organizations survive in the program, we found that certain program components, beneficiary health, care coordination ability, and market context (such as high-cost-growth markets) are associated with differing MSSP survival. CMS finalized a rule in December 2018 to overhaul the MSSP.²² While newly introduced flexibilities can reduce uncertainty for low-revenue ACOs, the findings from this study also suggest that the greatly shortened upside-only risk period may cause successful ACOs to leave the program. At least three years may be necessary to prepare for downside risk, though more research is needed.

CMS may be able to keep successful ACOs in the program by supporting ACOs as they develop competencies that allow them to achieve shared-savings bonus payments, strengthening the tie between payment and quality improvement, increasing support to ACOs that care for sicker patients (and addressing issues in Hierarchical Condition Categories scores), and investigating the effect of high-cost-growth markets on ACOs and how to adjust benchmarks accordingly. ■

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Partners, which consults about accountable care organizations (ACOs) and works with providers and ACOs. He is a visiting fellow at the Accountable Care Learning Collaborative. He has given speeches that included ACO research, for some of which he received travel expenses or small honoraria, and has attended multiple ACO conferences unrelated to this work. He has received grants from the Commonwealth Fund and the Gordon and Betty Moore

Foundation for work on ACOs unrelated to this work. Mark McClellan is an independent board member for Cigna, Johnson & Johnson, and Alignment Health Care; cochairs the Accountable Care Learning Collaborative and the Guiding Committee for the Health Care Payment Learning and Action Network; and receives fees for serving as an adviser for Cota and MITRE, all unrelated to this work.

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