

# All-Payer Value-Based Contracting in Organizations With Medicare ACOs

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The health policy community has encouraged the adoption of value-based payment models that hold health care organizations accountable for the total cost of care. In 2015, HHS Secretary Sylvia M. Burwell announced that 50% of traditional Medicare payment should be tied to quality and value through alternative payment models by 2018.<sup>1</sup> In 2022, the Center for Medicare and Medicaid Innovation announced a more ambitious goal of having all traditional Medicare beneficiaries in an accountable care relationship by 2030.<sup>2</sup>

One reason Medicare set goals for value-based payment was to encourage other payers to offer similar models. Multipayer participation in value-based models is needed to push health care organizations toward a tipping point at which the financial incentives to manage spending and improve quality overwhelm the prevailing fee-for-service (FFS) incentives to increase revenue by increasing volume. The Medicare Shared Savings Program (MSSP) is the nation's largest value-based payment model, now covering 11 million Medicare beneficiaries. Details about the MSSP including model structure, provider participation, and performance of participating accountable care organizations (ACOs) are publicly available. In contrast, little information is available about value-based payment arrangements in Medicare Advantage (MA) plans, commercial health plans, and Medicaid managed care programs.

Information about value-based payment models outside traditional Medicare is scarce. One group of analysts periodically writes about the growth of ACO models; in 2022 they reported that nearly 1000 ACOs had more than 36 million covered lives across all payers.<sup>3</sup> The reports are based on a proprietary database (Torch Insight) but do not discuss the prevalence of contracts by payer or the degree of contract risk. The CMS-sponsored Health Care Payment Learning & Action Network (HCP-LAN) periodically publishes national estimates of value-based payment based on health plan surveys. In 2022 it reported that nearly 20% of third-party payments were made through contracts where providers faced downside risk for losses.<sup>4</sup> Several studies have analyzed value-based contracting using data from provider groups. A 2016 study analyzed the percentage of patient revenue received through different types of value-based

## ABSTRACT

**OBJECTIVES:** To measure the prevalence of non-Medicare value-based contracting and participation in contracts with downside risk among organizations participating in the Medicare Shared Savings Program (MSSP).

**STUDY DESIGN:** Cross-sectional analysis of 2022 accountable care organization (ACO) survey.

**METHODS:** The author analyzed surveys from 100 organizations participating in the MSSP that reported the number of covered lives they have in value-based contracts in traditional Medicare (ACOs), Medicare Advantage (MA), commercial payers, Medicaid managed care organizations, Medicaid, and direct-to-employer arrangements. We analyzed the distribution of covered lives across shared-savings, shared-risk, and full-risk contracts and analyzed changes between 2018 and 2022.

**RESULTS:** Respondents reported 15.5 million covered lives in value-based contracts. All respondents have Medicare ACO contracts, and roughly 75% reported value-based contracts with commercial and MA plans. Approximately one-third reported such contracts with Medicaid managed care plans. Seventy percent of covered lives in respondents' Medicare ACO contracts included downside risk for losses compared with 51% of lives in commercial plans and 45% in MA plans. Compared with a similar 2018 survey, the proportion of respondents in value-based MA contracts doubled, and the proportion in commercial contracts rose by half.

**CONCLUSIONS:** Organizations that participate in Medicare ACO models have substantially increased their participation in value-based contracts with other payers. They reported a higher proportion of Medicare ACO covered lives in downside risk arrangements than in commercial or MA contracts.

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### TAKEAWAY POINTS

Little public information is available about value-based contracting outside traditional Medicare. This article provides all-payer contracting details from a 2022 survey of 100 organizations with Medicare accountable care organizations (ACOs).

- ▶ Approximately 75% of respondents have value-based contracts with commercial and Medicare Advantage (MA) plans.
- ▶ The proportion of covered lives with downside risk was 70% in Medicare ACOs, 51% in commercial plans, and 45% in MA.
- ▶ The proportion of respondents in value-based MA and commercial contracts rose by 100% and 50%, respectively, since 2018.
- ▶ Medicare ACOs have increased value-based contracting outside traditional Medicare but still take less downside risk with these other payers.

contracts (VBCs) in 33 large multispecialty medical groups and found that those with a higher proportion of risk-contract revenue had more advanced care management capabilities and were less likely to compensate employed providers based on productivity.<sup>5</sup> A 2019 study reported that one-third of organizations with ACO contracts had at least 1 contract with downside risk but did not identify the size of the contracts or the extent of the downside risk they faced.<sup>6</sup>

This study provides information about all-payer value-based contracting in 2022 based on a survey of a diverse group of provider organizations participating in Medicare ACOs, including details about the number of covered lives by payer category and degree of contract risk. It provides details about private payer contracting not available in the published literature by comparing 2022 results with information from a 2018 survey conducted by the author and colleagues to show how the risk-contracting portfolios of organizations participating in Medicare ACOs have evolved between 2018 and 2022.

## METHODS

This cross-sectional study used a web-based survey to gather information about the characteristics of VBCs across all payer categories for organizations participating in the MSSP in 2022.

### Sample

The survey was sent to all organizations in the MSSP during fall 2022. We did not solicit surveys from direct contracting entities but received several surveys from organizations participating in both the MSSP and direct contracting models. The point of contact for the survey was either the primary contact from the National Association of ACOs (NAACOS) database or the contact on the CMS-published list of 2022 MSSP ACOs. We received 100 responses for a 21% response rate.

### Tool

Survey questions were developed by the Institute for Accountable Care, and the survey was pilot tested with ACO executives on the NAACOS Policy Committee. The online survey was distributed

through the Qualtrics platform via an introductory email. Respondents received 3 reminder emails, which included a link to the full survey.

### Measures and Data

The primary measure of interest was the total number of covered lives in VBCs by payer category and level of contract risk. VBCs were defined as contracts with a total-cost-of-care spending target for a population of enrollees through which participants can earn shared savings or may have to pay back a portion of losses, depending on their performance. The payer categories were traditional Medicare,

MA, commercial, Medicaid managed care organization, Medicaid, direct to employer, and other. We asked respondents to report the number of covered lives in each payer category broken into 1-sided contracts (upside only), 2-sided contracts with shared risk, and 2-sided contracts with full risk. We also report on changes in risk contracting between 2018 and 2022 using data from a prior ACO survey.

### Analysis

This descriptive analysis shows the distribution of ACO covered lives by payer and type of risk contract in 2022 and the change in covered lives from 2018.

## RESULTS

The 100 organizations that participated in the 2022 survey reported 15.5 million covered lives under management in VBCs across all payers. We compared the characteristics of respondent ACOs with the universe of MSSP ACOs using published MSSP financial and quality results from 2021. Survey respondents were similar to MSSP ACOs in terms of their geography, year of initial MSSP enrollment, and participation in 2-sided models (**eAppendix** [available at [ajmc.com](https://www.ajmc.com)]). Respondents were larger on average than all MSSP ACOs (25,385 vs 21,300 beneficiaries, respectively) and more likely to be affiliated with a hospital (81% vs 59%).

Ninety-two percent of respondents reported covered lives by level of contract risk (**Table 1**). Seventy percent of respondents' Medicare ACO covered lives were in 2-sided risk contracts, including 7% in full risk. Fifty-one percent of commercial covered lives were in 2-sided risk contracts, with 9% in full risk. Forty-five percent of MA covered lives were in 2-sided contracts, including 18% in full risk. Respondents reported nearly 1.7 million lives in Medicaid managed care organizations and 900,000 in Medicaid value-based arrangements. Only a few respondents reported direct-to-employer contracts.

We compared the 2022 results with a 2018 ACO survey that collected similar information from 171 MSSP ACOs.<sup>7</sup> Between 2018 and 2022, the proportion of respondents with MA VBCs grew from

**TABLE 1.** Number of Covered Lives in Value-Based Contracts by Payer and Distribution of Lives by Contract Type

	Percent with value-based contract by payer	Number of covered lives		Distribution of covered lives by contract risk		
		Total (N= 100)	Reported by level of risk (n=92)	Shared savings (1-sided)	Shared risk (2-sided)	Full risk (2-sided)
Medicare ACO	100%	2,844,578	2,614,477	30%	63%	7%
Medicare Advantage	73%	1,726,778	1,638,534	55%	27%	18%
Commercial	75%	7,675,915	6,980,355	49%	42%	9%
Medicaid MCO	35%	1,682,789	1,573,389	58%	34%	8%
Medicaid	17%	984,800	924,800	59%	22%	19%
Direct to Employer	24%	324,785	290,885	46%	35%	19%
Other	16%	305,735	287,418	41%	0%	59%
Total	100%	15,545,380	14,309,858	48%	42%	10%

ACO, accountable care organization; MCO, managed care organization.

Source: Self-reported data from 100 health care organizations participating in Medicare ACO models in 2022.

35% to 74% and those with commercial VBCs rose from 50% to 76% (Table 2). The proportion of covered lives in 2-sided contracts also grew between 2018 and 2022 from 42% to 70% in traditional Medicare and 35% to 52% in commercial health plans but declined slightly in MA. We also compared these changes for a matched sample of 30 ACOs that submitted surveys in both years, with similar results (eAppendix).

## DISCUSSION

This study shows that organizations participating in the MSSP are expanding participation in value-based contracts outside Medicare and that the size of these contracts is growing. Nearly half of the respondents reported more than 100,000 value-based lives. Contracts with downside risk have also grown, and the proportion of the 2022 respondents' total covered lives in 2-sided risk contracts now exceeds 50%. Downside risk has grown most rapidly in the MSSP program because 2019 rule changes accelerated the timeline for mandatory downside risk. However, since 2018, the number of MSSP ACOs has declined and the number of total MSSP lives has remained flat. The current administration is trying to encourage MSSP growth through rule changes including reduced downside risk requirements beginning in 2024.<sup>8</sup>

The lack of information about value-based contracting outside traditional Medicare is a major knowledge gap for public policy. Payment is the primary lever used by public and private payers to encourage transformation in health care delivery. Despite the resources and attention that policy officials and health care organizations have devoted to value-based care, the lack of even basic descriptive information about value-based contracting outside Medicare makes it difficult to evaluate whether payment reforms have led to better outcomes or more efficient care.

Very few private payers have subjected their value-based payment models to independent evaluations. In a 2019 systematic review of studies examining the impact of ACO payment models on utilization and outcomes, 8 of 9 quasi-experimental peer-reviewed studies

**TABLE 2.** Changes in Risk-Contracting Prevalence and Contract Type Between 2018 and 2022

Description	Medicare ACO		Medicare Advantage		Commercial health plan	
	2018	2022	2018	2022	2018	2022
Survey year	2018	2022	2018	2022	2018	2022
Number of organizations	171	100	171	100	171	100
Percent reporting value-based contract	100%	100%	35%	74%	50%	76%
Total covered lives (millions)	3.9	2.6	0.7	1.6	6.3	6.3
Shared savings (1-sided)	58%	30%	50%	55%	65%	48%
Shared risk (2-sided)	41%	63%	34%	27%	20%	43%
Full risk (2-sided)	1%	7%	16%	18%	15%	9%

ACO, accountable care organization.

Source: Self-reported data from 100 organizations participating in Medicare ACO models in 2022 and 171 organizations participating in 2018.

of commercial ACO models evaluated a single program: the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract.<sup>9</sup>

Information about value-based contracting based on voluntary surveys is difficult to collect because many organizations view the information as sensitive. Results based on such surveys may or may not be representative of the universe of providers or payers. Mandatory reporting of this type of information would be helpful for research and policy. A few states such as Massachusetts collect and publish detailed data on participation in alternative payment models for major payers and provider groups,<sup>10</sup> but most states and the federal government do not. Although the results presented in this article may not be generalizable to all organizations participating in Medicare ACO programs, they do provide detailed, up-to-date information about value-based contracting in a large, diverse group of providers.

## Limitations

This study has several important limitations. One is that the survey response rate was only 21%. Respondents were larger on

## TRENDS FROM THE FIELD

average than MSSP ACOs generally and more likely to be hospital affiliated (81% vs 59%, respectively). Although this survey is likely not representative of all MSSP ACOs, it does provide a profile of the pace of payment reform based on a large sample of provider organizations. It is unknown how the bias toward hospital-affiliated respondents affects the non-Medicare risk-contracting results, but in 2021, hospital-affiliated ACOs were less likely than physician ACOs to be in 2-sided MSSP risk contracts (33% vs 52%, respectively).

Another limitation is that this study could not measure the relative size of respondents' fee-for-service business. It would be preferable to measure the proportion of total revenue in FFS vs VBCs, which would require respondents to report revenue by payer, type of payment, and contract risk. This information is more complicated to compile than covered lives, and providers view it as highly sensitive. The author did not request revenue data because of concern about reducing the response rates.

## CONCLUSIONS

To understand whether the collective investment in value-based models is paying off, better information about value-based contracting is needed. Payment model information published by the HCP-LAN is commonly cited in the media and academic papers and claims to represent 77% of the US market. However, the HCP-LAN results are only reported at the national level; it would be more valuable for policy if the HCP-LAN would report results by hospital referral region to show the prevalence of payment innovations in local markets. In addition, CMS could support research by collecting better information about payment and outcomes in MA contracts. More commercial payers also could share their data with independent researchers like Blue Cross of Massachusetts did with the Alternative Quality Contract, and more states could require payers to submit this information. As national and state policy makers continue to encourage value-based contracting, they should invest in collecting more data to help understand its impact. ■

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**eAppendix Table 1.** Comparison of 2022 ACO Survey Sample to All 2021 MSSP ACOs

	Value-Based Contract by Payer	Total (N=100)
Medicare ACO	100%	2,844,578
Medicare Advantage	73%	1,726,778
Commercial	75%	7,675,915
Medicaid MCO	35%	1,682,789
Medicaid	17%	984,800
Direct to Employer	24%	324,785
Other	16%	305,735
<b>Total</b>	<b>100%</b>	<b>15,545,380</b>
Source: Self-reported data from 100 medical groups and health systems.		

<sup>a</sup>Hospital Affiliated ACOs include those that include a hospital in the ACO or that participate in a health system that includes hospitals.

Source: Self-reported data from 100 organizations participating in Medicare ACO programs and the 2021 MSSP public use file.

**eAppendix Table 2.** Changes in Risk Contracting Prevalence and Contract Type Between 2018 and 2022: Matched Sample of 30 Organizations Reporting in Both Years

Description	Medicare ACO		Medicare Advantage		Commercial Health Plan	
	2022	2018	2022	2018	2022	2018
Survey Year	2022	2018	2022	2018	2022	2018
Number of Organizations	30	30	25	14	23	15
Percent Reporting VBC Contract	100%	100%	83%	47%	77%	50%
Total Covered Lives (millions)	1.1	0.9	0.8	0.2	3.1	2.2
Shared Savings (One-sided)	26%	48%	54%	45%	42%	63%
Shared Risk (Two-sided)	74%	52%	25%	36%	47%	21%
Full Risk (Two-sided)	0%	0%	20%	19%	11%	16%

Self-reported data from 100 organizations participating in Medicare ACO models in 2022 and 171 organizations participating in 2018.