Rural Health Value Policy Brief
Medicare Shared Savings Program: Rule Changes and Implications for Rural Health Care Organizations

PURPOSE

The Rural Health Value (RHV) team offers this summary of changes to the Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Program (SSP) that take effect in January 2023 for current participants, and in January 2024 for organizations applying in 2023 for a January 1, 2024 start. We focus on program changes that may support entry into the SSP for those healthcare organizations (HCOs) that have never participated in the SSP, and may facilitate reentry for those HCOs that had previously discontinued participation in the SSP. Consistent with the RHV vision to build and distribute actionable knowledge that helps create high performance rural health systems, the purpose of this document is to delineate changes to the SSP made by CMS in the Calendar Year 2023 Medicare Physician Fee Schedule Final Rule – Medicare Shared Savings Program that may make participation in the nation's largest value-based payment program more favorable for rural HCOs.

INTRODUCTION

The SSP is a value-based Medicare alternative payment model that generally retains fee-for-service payments (i.e., prospective payment system for hospitals, home health, and skilled nursing; cost-based reimbursement for Critical Access Hospitals, and fee-for-service for health professionals) while adding payment incentives (in the form of shared savings) for clinical quality and cost control performance. Groups of HCOs participate in the SSP by forming accountable care organizations (ACOs). Some ACOs currently participate in the SSP with only upside risk; that is, Medicare will share program savings with the ACO (assuming adequate quality performance). Other ACOs assume two-sided risk; that is, Medicare shares program savings with the ACO, but the ACO is also responsible for covering a portion of program losses if losses occur (downside risk). The percent of savings shared is greater if the ACO also agrees to accept downside risk.

Thus far, many rural ACOs have been reluctant to assume downside risk, but under current rules they are required to begin assuming downside risk by the third year of a five-year glide path and assume the highest level of risk (level E) in their fourth year (see Table 1). The SSP is considered the major public policy strategy for achieving the Center for Medicare & Medicaid Innovation aim that "all Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030".[1] The new rule also addresses the CMS broader goal of increasing participation in the SSP, especially among low-revenue ACOs and ACOs lacking previous performance-based payment experience. Through calculation of an advanced payment (including quarterly per-beneficiary payments) and adjustments to quality scores, the rule advances CMS' overall strategy of growth in value-based care.[2]

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[1] https://innovation.cms.gov/strategic-direction

[2] CMS. (2022). *Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule - Medicare Shared Savings Program*. Accessed 11/28/2022, https://edit.cms.gov/files/document/mssp-fact-sheet-cy-2023-pfs-final-rule.pdf

Changes in the SSP are included in the 2023 Medicare Physician Fee Schedule (PFS) final rule, published November 18, 2022. The changes make participation in the SSP more favorable for low revenue ACOs and ACOs lacking performance-based payment experience. They also encourage long-term participation in the program, including allowing ACOs to remain in Level E indefinitely (not requiring that they move from the Basic Track to the Enhanced Track). Program changes include implementation of Advanced Interest Payments (AIPs), initial five-year agreements staying at Level A (one-sided risk), protections against unrepresentative benchmarking, reductions to administrative burden, and more.

SUMMARY AND IMPLICATIONS OF THE FINAL RULE

The RHV team offers a summary analysis of SSP changes in the final rule and supplemental information to help readers understand implications of the changes. Table 1 provides a description of the various SSP levels, Table 2 illustrates the different time periods when ACOs are required to transition to a two-sided risk model (accept downside risk), and Table 3 details the changes to the SSP, potential rural health impacts, and participation considerations.

Table 1: Current Shared Savings Program Participation Tracks and Levels (in Basic Track)

Tracks/Levels	Details
BASIC Track	In the BASIC Track, ACOs automatically advance to the next level (certain ACOs have the option to remain at Level B for an extra year).
Level A (BASIC)	Upside only, shared savings <40%
Level B (BASIC)	Upside only, shared savings <50%
Level C (BASIC)	Two sided risk (accepting downside risk), shared savings <50% Shared loss limit = lesser of revenue or benchmark based loss Lowest loss-sharing limit
Level D (BASIC)	Two-sided risk, shared savings <50% Shared loss limit = lesser of revenue or benchmark based loss Greater loss-sharing limit than Level C
Level E (BASIC)	Two-sided risk, shared savings <50% Shared loss limit = lesser of revenue or benchmark based loss Greater loss-sharing limit than Level D
ENHANCED Track	Two-sided risk, shared savings <75% Shared loss = 40-75% (maximum = 15% of benchmark expenditures

Table 2: 2023 Rule Change for SSP Participation Options

ACO Type	Experience Level	1st agreement period (5 years)	2nd agreement period (5 years)	Subsequent Agreement Periods
New ACO	Inexperienced	A*, A, A, A, A	A, B*, C, D, E	Remain in Level E indefinitely or move to ENHANCED track
	Experienced	E, E, E, E, E		
Re-entering	Inexperienced (former BASIC track Level A or B)	A, B, C, D, E	E, E, E, E, E	Remain in Level E indefinitely or move to ENHANCED track
	Inexperienced (former track 1)	A, A, A, A, A	A, B, C, D, E	
	Experienced	E, E, E, E, E		
Renewing	Inexperienced	A, B, C, D, E	E, E, E, E, E	Remain in Level E indefinitely or move to ENHANCED track
	Experienced	E, E, E, E, E		

*Levels A and B are upside risk only.

	BASIC				ENHANCED
	Levels A + B	Level C	Level D	Level E	Years 1-5
Shared Savings Rate (upside risk)	<40%	<50%	<50%	<50%	<75%
Shared Loss Rate (downside risk)	N/A	30%			40-75%

Table 3: Rule Changes and Implications for Rural Health Care Organizations

	Rule Change	Impact on Rural Health	Impact on Participation Considerations
Advanced Interest Payments (AIPs)	Eligible ACOs receive a one-time fixed payment of $250,000 and quarterly per-beneficiary payments for the first 2 years of an agreement period. To qualify for AIPs, an ACO must: ● Be joining the SSP for the first time, ● Be designated both low revenue, and inexperienced with risk-based Medicare ACO models ● Not be owned or operated by a health plan. AIP per-beneficiary-per-quarter (PBPQ) payments are capped at $45 and 10,000 beneficiaries (an ACO can have more than 10,000 beneficiaries and qualify, but payments are only dispersed for the first 10,000) . The per-beneficiary payments are based on a risk factor-based score that consider dual eligibility status, Part D Low Income Subsidy program enrollment, and Area Deprivation Index national percentile ranking of the census block group in which the beneficiary resides. AIPs' spending must be limited to: ● Improving healthcare infrastructure, ● Increasing staffing, and/or ● Addressing non-medical needs when appropriate.	Increases upfront capital and additional PBPQ payments. PBPQ payments are adjusted, with higher payments for beneficiaries with higher need. Provisions for low-revenue and inexperienced ACOs are intended to make the model more attractive to more providers, and address issues of access. Both purposes are consistent with making the model more attractive in rural places, which CMS recognizes in its summary of the rule.	AIPs give ACOs operating in low-penetration areas access to additional funding as an initial investment, followed by two years of additional payments. The intent is to assist in the cost of building infrastructure and staff for care management. This will benefit provider organizations serving at-need populations in both urban and rural areas. Rural ACOs will most likely benefit from this investment opportunity as they enter the BASIC track with no downside risk.

	Rule Change	Impact on Rural Health	Impact on Participation Considerations
Increased transition time between SSP levels in the Basic Track, and option to stay in the Basic Track	Inexperienced ACOs can participate in one full five-year agreement under Level A. In the next agreement, they are allowed two more years in pure upside risk, which is a total of 7 years (an additional 5 years without downside risk compared to previous rules). See figures below. After completing the transition to Level E of the Basic Track, ACOs may choose to remain in that status indefinitely (not change to the Enhanced Track and higher downside risk).	Many rural ACOs would qualify as both inexperienced and low-revenue, meaning they would be able to participate in shared savings without downside risk for seven years. They would benefit from the AIP during their first two years, further enabling them to build the infrastructure and staffing expertise to succeed in a two-sided risk environment after seven years.	Upside-only risk sharing would allow ACOs to gain experience and capital before being exposed to downside risk. The intent of the initial five-year agreement is to allow additional time to gain vital experience in cost and quality management. CMS, in the proposed rule, considered allowing inexperienced ACOs to apply for a second five-year agreement at no downside risk, but the final rule did not adopt that extended time.
Changes to the Minimum Savings Rate (MSR)	Low-revenue ACOs can receive half the regular rate of shared savings without hitting the MSR, so long as they meet quality performance standards.	Low-revenue ACOs are disadvantaged in their ability to hit the MSR, so allowing ACOs to receive at least some amount of shared savings allows for more reliable funding streams.	ACO participation was often disincentivized by the difficulty of hitting the MSR. More consistent and reliable payments create easier transitions into the SSP.
Accountable Care Prospective Trend (ACPT)	Currently, cost benchmarks are calculated using national and regional growth rates. ACPTs introduce a third component to that calculation.	Currently, when ACOs operating in rural areas succeed in lowering care costs, they inadvertently lower the overall regional trend of costs, essentially penalizing themselves for creating savings. The addition of ACPTs	ACPTs are an attempt to address the “rural glitch,” which has been a barrier for rural ACO’s entry to the SSP. Adding ACPTs is a significant step towards reducing that

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	ACPTs are a risk-adjusted flat dollar amount computed by CMS to represent a prediction of cost trends using a national population.	to benchmark calculation dilutes the impact of regional trends on the setting of benchmarks. If the new calculation creates higher shared losses than what would have been created with the old methodology, CMS will recreate the benchmark without the ACPT.	barrier, but the impact of the addition is as yet unknown
Reduction of Negative Regional Adjustment Cap	Cost benchmarks are adjusted by comparing the expenditures of the assigned beneficiaries in the ACO to the overall regional population. Previously, there was a +/-5% cap on this adjustment to ensure ACOs with high-need beneficiaries were not punished and to avoid ACOs seeking out lower-risk beneficiaries. Now, the positive cap remains at 5%, but the negative cap is reduced to 1.5%. Another adjustment will be to decrease the negative regional adjustment when an ACO';s proportion of dually eligible beneficiaries increases or its weighted-average prospective Hierarchical Condition Category risk score increases ACO's MIPS quality performance scores may be adjusted with up to 10 bonus points based on (1) high quality performance and (2) providing care for a higher proportion of at-need or dually eligible beneficiaries. The at-need population is	Low revenue and rural ACOs often treat high-need beneficiaries and treat a larger percentage of the overall regional population, meaning that their negative regional adjustment often hits the 5% cap. Reducing this cap further protects rural ACOs from unfair benchmarking.	This change further reduces the risk for rural ACOs joining the SSP since it protects the ACO from inappropriately lower benchmarking and therefore increases the likelihood for shared savings.

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	determined based on the Area Deprivation Index (ADI) score of the area, enrollment in Low Income Subsidy, and dual eligibility status.		
Adjustment for Prior Savings	Prior savings adjustments include a portion of savings generated by ACOs added back into the benchmark for the next year, so that achieving savings year after year is easier. CMS will now adjust benchmarks based on either a prior savings adjustment or an ACO's positive regional adjustment (whichever is higher). Prior savings adjustments can also offset negative regional adjustments.	Rural ACOs that experienced robust performance year after year would eventually be punished by their own success, since benchmarks would continue to decrease making it more difficult to achieve savings. At some point, there is no more room to achieve savings. This rule slows benchmark decreases by adjusting for previous savings.	The difficulty of achieving significant savings year after year is a strong disincentive for participation. Accounting for previous savings can provide a more long-term path to success for participating ACOs
Risk Score Growth Cap Adjustment	Previously, within a 5 year agreement period, an ACO's beneficiaries may not experience a growth in risk score exceeding 3 percent. Under the new rule, an ACO's demographic risk scores may be considered prior to applying the 3 percent cap. These risk scores are calculated by comparing the average costs for an ACO's beneficiaries relative to the average beneficiary.	For rural ACOs that serve high-need, medically complex populations, risk can change significantly within 5 years. Allowing flexibility within the 3 percent cap can alleviate restraints on proper benchmarking for these ACOs.	A significant barrier to SSP entry is the potential for loss in shared savings given the risk of the population they serve. Reducing the penalties for caring for high-need populations makes participation less risk-prone.

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Sliding Scale for Shared Savings and Losses	Previously, ACOs earned shared savings if they met an all-or-nothing threshold based on quality performance. Under the new rule, if an ACO falls below the 30th percentile in quality performance but is at least in the 10th percentile in one of the four outcome measures, they can earn a percentage of generated savings based on their overall performance.	Financial uncertainty is a significant issue for rural ACOs. Eliminating payment cliffs, in which minor changes in quality performance result in the complete loss of payment, allow low-revenue ACOs to better plan for the future.	Ensuring predictable savings for ACOs makes joining the SSP a more financially viable option.
Transition to eCQM/MIPS Reporting	Two new Social Determinant of Health (SDOH) measures and health access adjustments will be incorporated into new quality measurement through eCQM/MIPS. The final rule extends the incentive for reporting eCQMs/MIPS CQMs through performance year 2024, allowing an additional year to gauge performance before full reporting of measures is required.	The health access adjustment provides additional relief for rural ACOs that serve a higher proportion of at-need beneficiaries, allowing improved scoring on qualifying measures and potentially increasing shared savings.	The transition to new reporting measures and the inclusion of SDOH and services availability reduce barriers to rural ACO participation in the SSP. The extended time to full reporting of eCQMs provides more time to prepare for full reporting. However, the National Association of ACOs has asked CMS to delay implementation longer because of the complexity of collecting the data from multiple electronic records across different systems who comprise the ACO. This may be an issue for at least some rural ACOs.

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Reduction of Administrative Burden	ACOs, under the new rule, will no longer be required to submit marketing materials to CMS for review. Beneficiary notices of participation in the ACO are now only required once per agreement period (along with one follow-up 180 days after initial outreach). ACOs can now qualify as Organized Health Care Arrangements (OHCAs), which allow for easier data sharing and access to claims data. Instead of providing detailed plans for application to the SNF 3-Day Rule Waiver, ACOs only have to submit attestations that they have created those plans.	Administrative burden reduction for inexperienced and low-revenue ACOs operating in rural areas allows them to channel resources to other important priorities while still complying with CMS rules.	The burdens of joining the SSP are slightly reduced by these new rules, which require less time spent in compliance and more time working towards creating and operating the ACO.

The Rural Health Value team would like to acknowledge John Dickens, MPH student at the University of Iowa, for his support in developing this brief.

GLOSSARY:

Accountable Care Prospective Trend (ACPT): A flat dollar amount set by CMS that is risk-adjusted and projects the cost trends of an ACO using an assigned national population

Advanced Interest Payments (AIP): Upfront payments to eligible ACOs that must be paid back after a certain period of time. Provides capital and immediate funding for new ACOs to operate in the SSP program.

Electronic Clinical Quality Measures (eCQM): Tools that aid CMS in measuring and tracking quality in healthcare services from ACOs and other providers, generated by electronic health records (EHR).

Inexperienced ACOs: Less than 40 percent of an ACO's providers have participated in Tracks 1+, 2, 3, BASIC Levels C, D, or E, ENHANCED, or a different risk-based Medicare ACO program.

Low revenue ACOs: An ACOs' total participant's Medicare revenue is less than 35 percent of the total Medicare expenditures for the ACO's assigned beneficiaries.

Medicare Shared Savings Program (MSSP): Flagship CMS program created with the aim of transitioning the country to value-based care payment methods. It is the program that houses Medicare ACOs.

Merit-Based Incentive Payment System (MIPS): A data collection system that ties value to payment using four measures – quality, improvement activities, promoting interoperability, and cost.

Minimum Savings Rate (MSR): The minimum rate at which an ACO must achieve savings in order to receive any shared savings payments.

Organized Health Care Arrangements (OHCAs): Healthcare provider entities (now including ACOs) that may use a single, joint notice to CMS that covers all the participating covered entities.

Per-Beneficiary-Per-Quarter Payments (PBPQ Payments): A type of AIP that is calculated by the amount and type of beneficiaries that are served by an ACO. PBPQ Payments are paid quarterly for 2 years and are capped at $45 dollars each and 10,000 beneficiaries total.

Skilled Nursing Facility (SNF) 3-Day Rule Waiver: A waiver for the CMS requirement that a beneficiary have a minimum 3-day inpatient stay to be eligible for post-acute care service coverage.

Social Determinants of Health (SDOH): The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (WHO).

(November 2022; revised May 2025)

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Developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $500,000 with 0% financed with non-governmental sources. The contents are those of the authors(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.