From noise to signal: How ACOs use analytics to gain confidence in a changing CMMI landscape

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APRIL 24, 2026

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Agenda

Program decisions – **Chris Smith**	Participant decisions – **Zach Davis**	Performance opportunities – **Noah Champagne**
Provider Incentive Gap – **Brent Jensen**	Feedback loop – **Francesca Hammerstrom**	

Program decisions

Chris Smith

MSSP and LEAD – Decision points

Program stability

Capitation payments

High Needs

Benchmark methodology

Program stability

Stability of program updates in CMS model vs CMMI model

Examples of changes in DC/REACH:

- Demographic risk score change/optionality in PY2024
- RTA corridor in PY2024
- PY2026 methodology updates (released summer of 2025)
  - Quality withhold increase (2% => 5%)
  - New risk score growth cap (second cap relative to 2019)

High Needs

This population may be larger than you think

Eligibility criteria:

1. Impaired mobility
2. Signs of frailty (claim)
3. Moderate to Severely Frail (index)
4. Risk score >= 3.00 if Aged/Disabled
5. Risk score >=0.35 if ESRD
6. [2.0-3.0 AD risk score OR 0.24-0.35 ESRD risk score] AND 2+ unplanned hospital admissions in prior 12 mo's
7. 45 SNF days in prior 12 mo's

Milliman ACO Builder, data through October 2025. Applies ACO REACH assignment methodology with LEAD High Needs criteria overlaid. Final LEAD risk score model details have not yet been released nor incorporated.

Proportion of national 2025 lives by status in simulated REACH/LEAD population:

Program	Aged & Disabled	ESRD	High Needs
ACO REACH	99.37%	0.63%	N/A
LEAD	86.02%	0.02%	13.95%

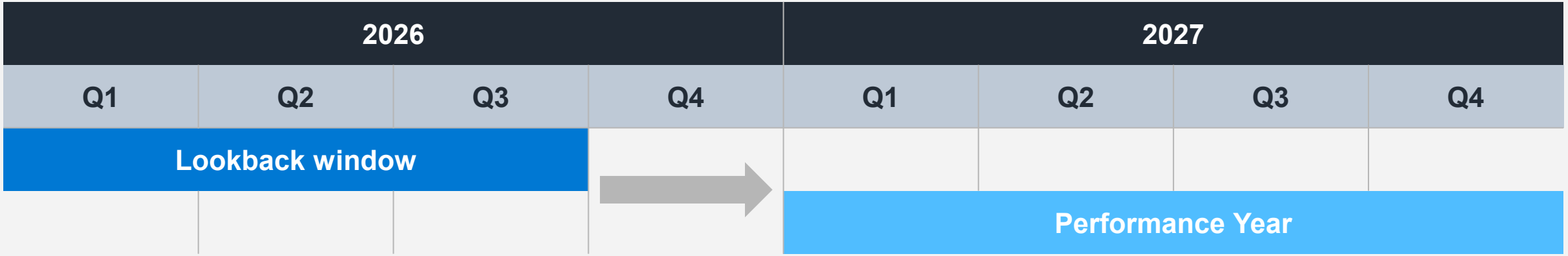
Capitation payments

Predictable monthly cash flow

"With capitated payments, health care providers get steady, predictable cash flow that is not tied to the number of services they provide. This flexibility frees health care providers to deliver care in innovative and flexible ways…" (RFA page 69)

Options:

- Total Care Capitation (Global only)
- Primary Care Capitation – Base + Enhanced
- Non-Primary Care Capitation
- Advanced Payment Option



Benchmark methodology

Understand how your ACO's benchmark will be constructed

Historical component (2024-26)

Three-way blended trend factor (like MSSP)

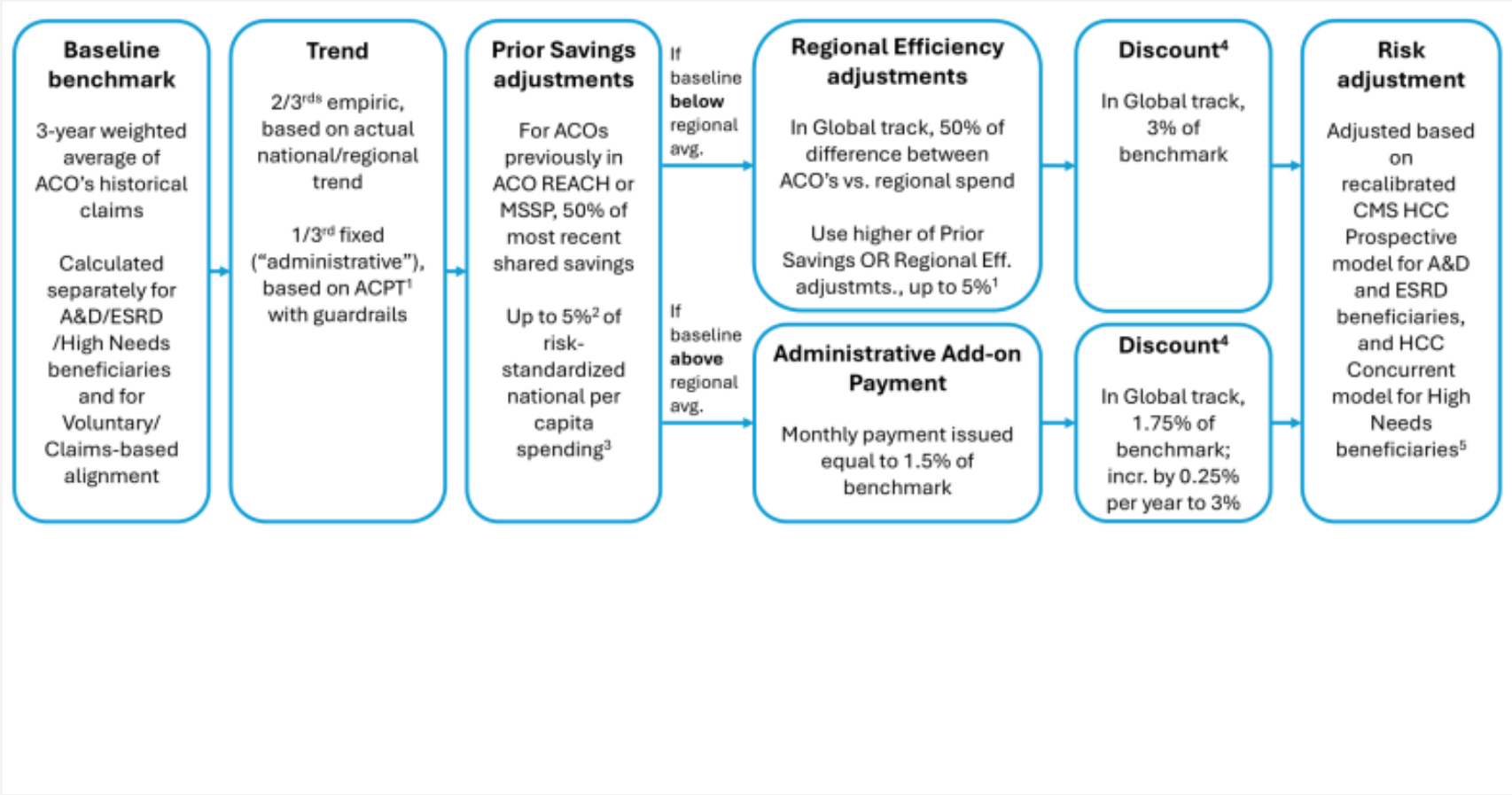
Baseline efficiency

- Efficient: Regional adj. or Prior Savings adj., subject to cap
- Inefficient: Administrative add-on payment (1.5%)

Discount

- Efficient: 3%
- Inefficient: 1.75% (graduates to 3% in later years)

CMMI LEAD RFA, Figure 2



Benchmark methodology cont.

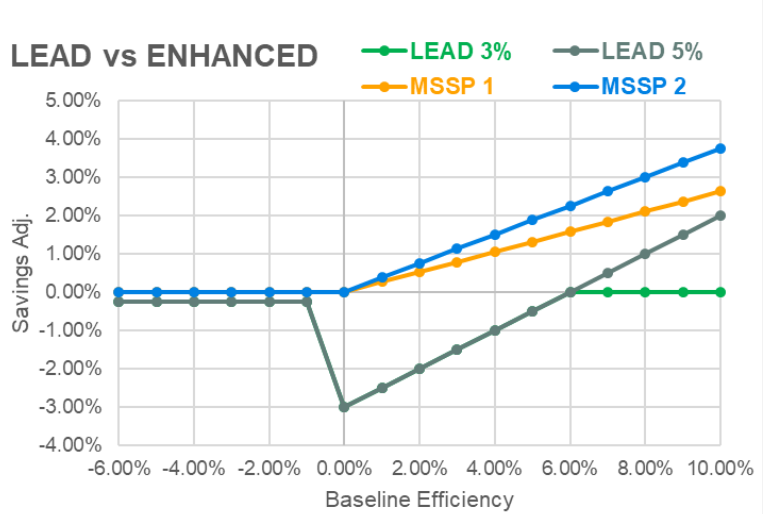
Understand how your ACO's benchmark will be constructed

Takeaways:

- Both LEAD and MSSP mitigate risk of negative regional adjustment
- For efficient ACOs, subsequent agreement periods in MSSP allow you to increase the regional benchmark adjustment quicker
- The slight financial headwind for inefficient LEAD ACOs will increase YoY as the discount rises
- For LEAD ACOs with prior MSSP experience, the 3% cap on benchmark adjustment disallows any benchmark tailwinds (due to the 3% discount)
  - For LEAD ACOs without prior MSSP experience, the 3% discount can be surpassed if the regional efficiency is 6%+ (i.e., a 3%+ regional efficiency adjustment)

Assumptions:

- 0% prior savings adjustment
- Two Global LEAD scenarios:
  - 3% cap (i.e., prior ACO experience)
  - 5% cap (i.e., newly entering ACO)
- Two MSSP Enhanced scenarios:
  - 1st agreement period (i.e., 35% regional adj.)
  - 2nd agreement period (i.e., 50% regional adj.)



Participant decisions

Zach Davis

The application window is open now.

Apply now, decide later.

LEAD application portal opened March 31 and closes May 17, 2026 — a 47-day window.

Applying does not obligate you to participate. Applicants who are accepted may choose to withdraw before the final deadline.

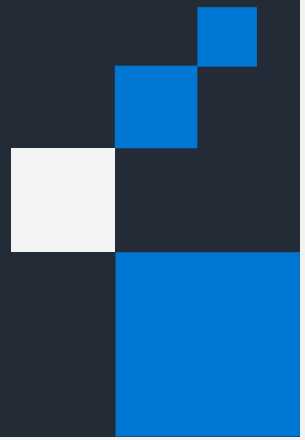
ACOs can apply for MSSP and LEAD

Apply now to preserve optionality while you complete operational and financial analysis. The decision to participate is separate from the decision to apply.

Deadline to choose is September 8

Where are you coming from?

Where you come from helps from the decision



1

MSSP

2

ACO REACH

3

New to Risk

4

Health Systems

MSSP Providers: Where you are in your rebase cycle?

When you rebase could help determine your path

4+ Years Out (2026 AP* Start)

Staying put may be best. Conduct only a high-level LEAD review — your current trajectory is likely working in your favor.

2–3 Years Out (2024/25 AP Starts)

ACPT pressure is real. Rebasing resets your benchmark back to a 50% haircut. LEAD's 10-year no-rebase structure may look attractive after accounting for that reset.

1 Year Out (2023 AP Start)

LEAD's 10-year structure deserves serious analysis. Key question: how much future upside will you give up to lock in stability now?

AP = agreement period start year

ACO REACH Participants

Choosing Your LEAD Track

REACH Global Track

The natural continuation for sophisticated performers who understand risk and population management. Designed for those already succeeding in full-risk arrangements.

REACH Professional Track — The Sleeper Pick?

Core CMMI benefits without the discount rate hurdle.

Durability note: MSSP’s Enhanced would have higher initial net savings but will rebase every 5 years, twice over LEAD's 10-year window.

New to Risk: The group with the most to gain

High-needs populations. Dual-eligible. Rural.

LEAD was specifically designed for you — But is there enough time?

- 1.5% Administrative Add-On Capitation
- High Needs Beneficiary Category
- Flexible Attribution
- 1.75% Discount, 0.25% Ramp Up

Health Systems: Structural complexity requires a tailored approach

Primary care and specialist footprints are intertwined

Operational Tools Worth Evaluating

- Benefit Enhancements
- Preferred Providers & CARA
- Capitated Payments

The Path Forward: Same decision, different variables

Every bucket faces the same fundamental decision — with different options, financial thresholds, and risk profiles.

Understand your bucket

Identify which of the provider types describes your situation and what the model means for you specifically.

Know your numbers

Accurate, independent assessment of your claims data, benchmark history, and financial position is the foundation of every decision.

Make your decision

The application window is 47 days. The time to begin this analysis is now.

Performance opportunities

Noah Champagne

Identifying care management opportunities

Grouping claims into clinical domains/categories that align with how patients interact with the healthcare system (e.g., IP Events, Ambulatory Surgery Events, etc.)

- Comparing patterns within attributed population to various benchmarks
  - National
  - Regional
  - Other ACOs

Grouping claims into events can provide more meaningful signals than examining benefit service categories (more aligned with how services are paid)

Are the opportunities actionable?

- Care management programs
- Relationships with providers

Detecting claims anomalies early

Analyze emerging claims patterns to identify potential areas of:

- Fraud (e.g., Catheters)
- Waste and Abuse (e.g., Skin Substitutes)

Develop capabilities to identify anomalous claims patterns and direct beneficiaries away from suspect providers and/or begin regulatory action

Develop workflow to provide observed evidence

Risk score improvement

HCC Recapture

- Provider Profiling
- Benchmarking to competitors (other ACOs, similar providers, etc.)
- Set achievable targets
- Consider alignment with compensation

HCC Frequency Benchmarking

- Regional and national comparisons
- Are differences based on coding differences or population differences?

Risk score suspecting

- Pharmacy claims
- Machine learning (or to be “on trend” we can call it AI)

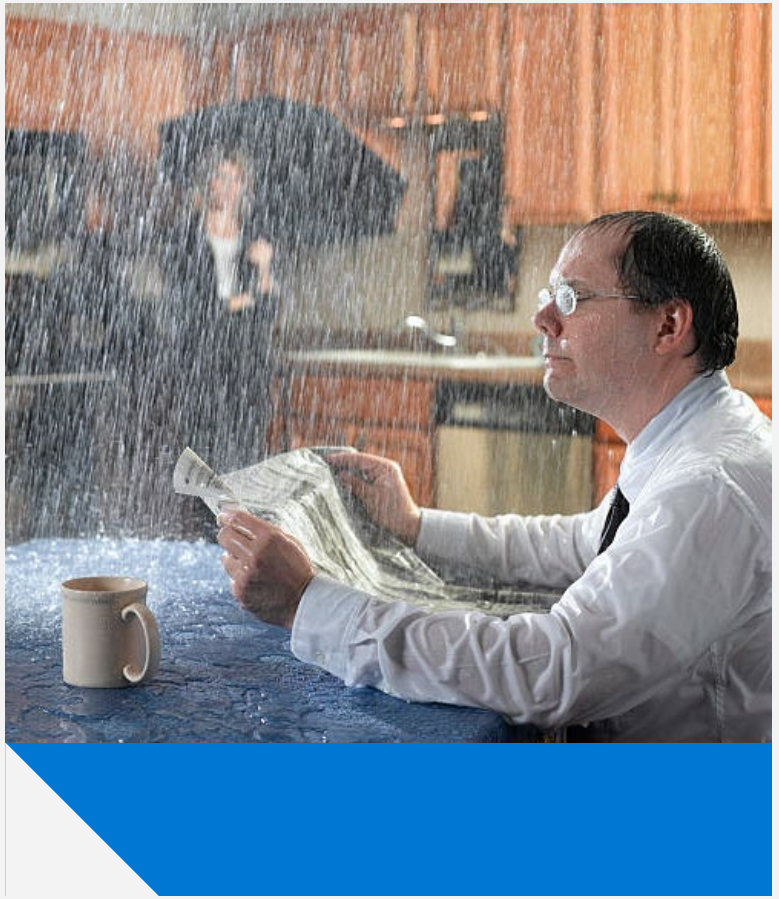
Managing steerage/leakage

Understanding leakage in current at-risk population

- Which services
- From which providers
- To which providers

Physician education

- Available in-network providers
- Analysis on effectiveness of providers
  - E.g., Specialists, SNFs, etc.



Positioning vs. opportunity

Metric	Provider X	Provider Y
Estimated Gross Savings	1.0%	4.0%
Opportunity Relative to Benchmarks	10%	5%
Risk Score Recapture Rate	50%	80%

The Incentive Gap: Turning shared savings into shared behavior

Brent Jensen

Milliman

Shared savings distribution method risks

Appropriately managing these risks is key to a successful shared savings distribution model

Incentive Risk

Misaligned incentives between the ACO and the provider

Goodhart's law – when a measure becomes a target, it ceases to be a good measure

Diffusion Risk

Shared savings are distributed to provider groups, but individual providers drive shared savings

Panel Risk

Panel size and morbidity

When panel size drives distributions, it isn't a good model

Without risk adjustment, distribution can't work properly

Timing Risk

Settlement occurs long after the care is provided

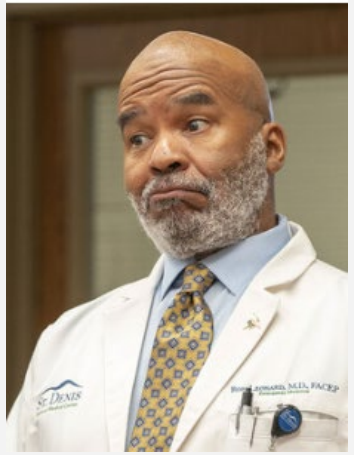
Four doctors, different distribution scenarios

Dr. Yang

- 250 beneficiaries
- High risk patients
- Good cost management
- Average quality

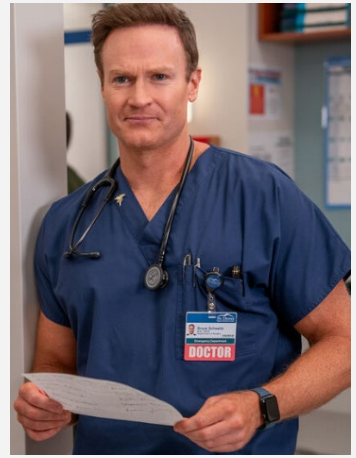
Dr. House

- 400 beneficiaries
- Low risk patients
- Avg cost management
- High quality



Dr. Ron

- 500 beneficiaries
- Average risk patients
- Poor cost management
- Low quality



Dr. Bruce

- 150 beneficiaries
- High risk patients
- Good cost management
- Average quality

The data tells the story

Building the right distribution model

	TIN A	TIN B	TIN C		
Metric	**Dr. Yang**	**Dr. House**	**Dr. Ron**	**Dr. Bruce**	**ACO Total**
Population					
Attributed Lives	250	400	500	150	**1,300**
Avg. HCC Risk Score	1.52	0.81	1.08	1.44	**1.12**
Expenditures					
Total Expenditures	$2,535,000	$2,400,000	$4,500,000	$1,492,200	**$10,927,200**
Raw PMPM	$845	$500	$750	$829	**$700**
Risk-Adjusted PMPM	$556	$617	$694	$576	**$630**
Benchmark					
Benchmark PMPM	$690	$690	$690	$690	**$690**
Risk-Adjusted Benchmark PMPM	$1,048	$559	$745	$993	**$775**
Regional Efficiency Ratio	0.91	0.88	1.14	1.01	**0.91**
Quality & Utilization					
Quality Score (0-100)	74.0	88.0	71.0	82.0	**78.1**
Preventable Admissions per 1,000	42.0	38.0	67.0	51.0	**51.4**
ED Utilization per 1,000	310.0	300.0	490.0	360.0	**381.9**
AWV Completion Rate	68.0%	71.0%	54.0%	63.0%	**63.0%**
Savings					
Gross Savings					**$1,158,000**

The data tells the story

What happens if distribution risks aren't properly addressed?

	TIN A	TIN B	TIN C	
Metric	**Dr. Yang**	**Dr. House**	**Dr. Ron**	**Dr. Bruce**
Savings distribution scenarios				
Risk Adjusted Benchmarks	$611,000	$282,000	($30,000)	$296,000
Incentive Risk				
Quality Only	($90,000)	$976,000	($107,000)	$380,000
AWV Utilization Weighted	$511,000	$817,000	($274,000)	$104,000
Diffusion Risk				
Risk Adjusted Benchmarks by TIN	$611,000	$282,000	($265,000)	
Risk Adjusted Benchmarks by TIN	$611,000	$282,000	($204,000)	($61,000)
Panel Risk				
Attributed Life Weighted	$223,000	$356,000	$445,000	$134,000
Non-Risk Adjusted Benchmarks	($158,000)	$1,202,000	$184,000	$(70,000)

Shared savings distribution

The ACO has earned shared savings (or shared losses) – what to do with the money?

Best practices for funds flow and incentive structure design

Align the distribution model align with the broader program

Establish a transparent approach, consider fringe cases

Regular data-based projections shared with participating providers during PY

Provide interim payments to align behaviors with rewards

Ensure distributions reach those driving overall results

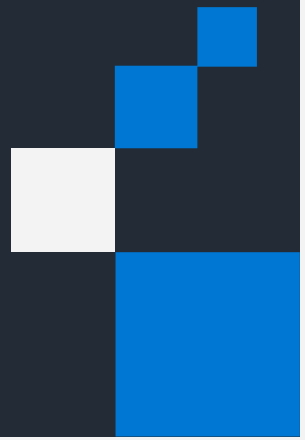
Use data to drive projections and results

Feedback loop

Francesca Hammerstrom

Data-driven decision-making is essential for VBC/ACO success

Key capabilities for value based care organizations



Financial Analysis

- Analyze risk contract terms
- Understand areas of reduced revenue due to converting services from FFS to risk financials
- Set budgets & targets for savings
- Monitor progress

Right-Size Utilization

- Convert financial budgets & savings targets to utilization rates & unit cost requirements
- Identify areas of excess utilization & cost
- Develop targeted interventions to drive savings

Manage Patients

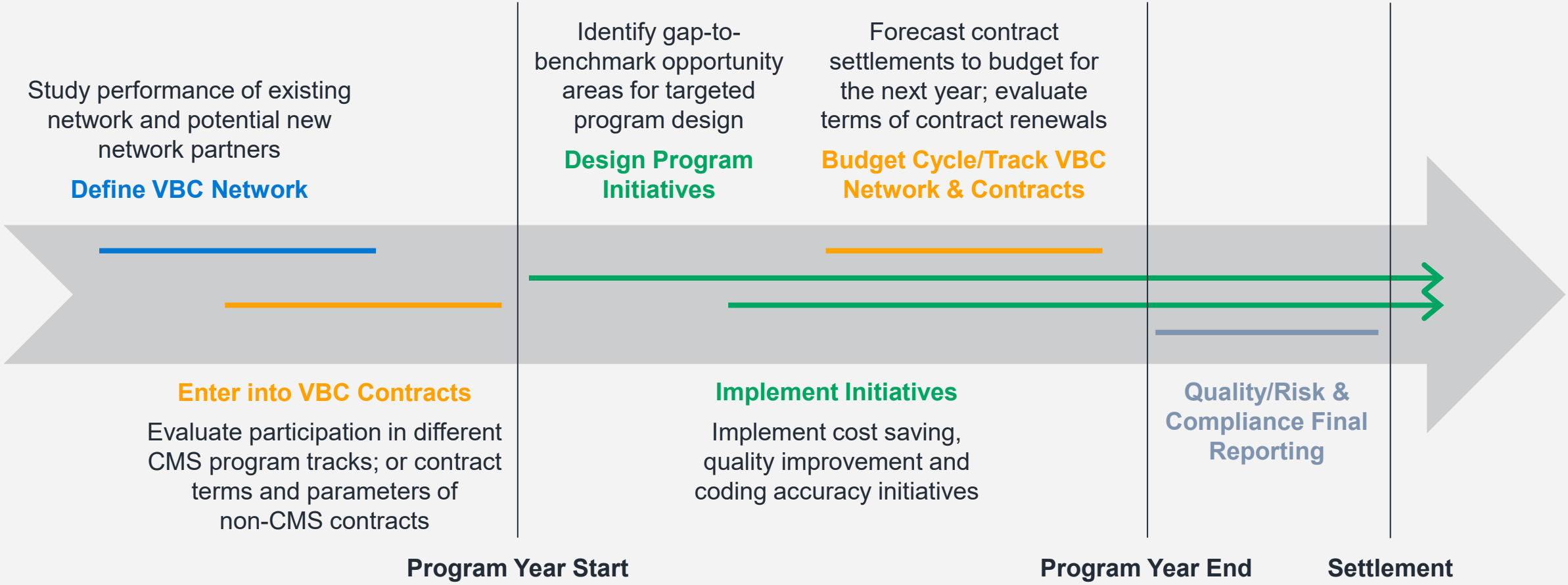
- Stratify & risk patients for targeted outreach by care coordinators
- Identify and close quality and risk coding gaps
- Addressing health equity through SDOH analysis and programs

Physician Engagement

- Measure and report physician partner performance
- Evaluate the broader network of physician partners and non-partners

Ad Hoc Analytics

Annual cycle of activity for an VBC contract



A comprehensive approach

The MedInsight Value-Based Care Platform

Bundles

Starting the VBC journey

Organizations often take their first steps with bundled payment programs, using data and benchmarks to manage inpatient care—no dedicated VBC team required.

ACO Builder

Advancing decision-making

As organizations progress, ACO Builder equips them with the modeling tools needed to evaluate opportunities, design contracts, and manage risk for ACO participation.

VBC Analytics

Evolving with advanced analytics

As VBC programs mature, MedInsight's advanced analytics enable tailored analyses, better risk management, and robust business intelligence.

Innovation Portal

Reaching advanced capabilities

At the leading edge, the Innovation Portal empowers data scientists with access to comprehensive data and advanced tools, driving innovation and continuous improvement.

Epic

Leveraging existing tools

Early VBC efforts are tracked and managed through existing EMR systems like Epic, providing an accessible foundation for VBC management.

VBC Insight

Scaling with targeted analytics

Deeper VBC engagement brings the need for specialized analytics. VBC Insights supports strategic planning and daily operations for ACOs.

VBC Contracts

Managing growing complexity

With multiple VBC contracts, MedInsight simplifies performance tracking and outcome optimization, making complex management easier.

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