

## Payment Calculation and Distribution

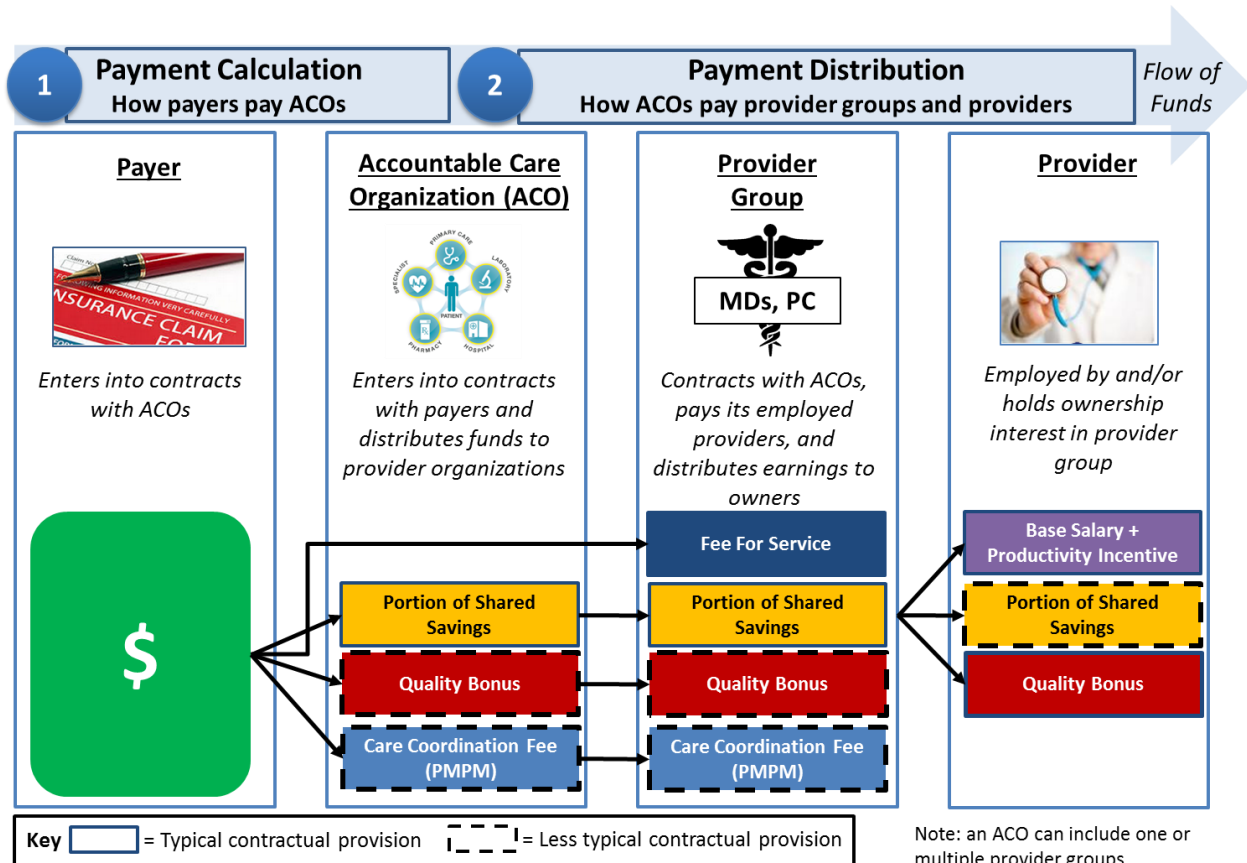
### Background

When an ACO signs a shared savings contract with an insurer, the ACO becomes eligible to earn payments that represent a share of savings it achieves on medical spending for a defined population. The ACO, in turn, may distribute the savings to the ACO's member organizations such as provider groups or hospitals, which provide services for the ACO's attributed population. The ACO may also retain a portion of shared savings to invest in shared infrastructure used to care for the attributed population. Provider organizations that receive shared savings payments from an ACO may in turn pass these along to providers, either in whole or in part, according to formulas they devise to reward provider performance. The shared savings paid to an ACO by a payer and in turn to the ACO's providers is known as an incentive payment, because it is incremental to what a provider will receive on a fee for service basis. In most shared savings payment arrangements, the savings generated are split between the provider and the payer.

The process used to determine the portion of cost savings that an ACO receives is referred to as payment calculation. How the ACO distributes those savings among providers and/or provider groups, or otherwise compensates service providers within the ACO, is referred to as payment distribution.

The diagram below depicts common ways in which funds flow from a payer to providers participating in a shared savings contract.

### Shared Savings Payment Terminology and Structure



Note a few key features associated with the flow of funds:

- Provider groups still earn a fee-for-service payment directly from the payer
- Providers' compensation is generally composed of a combination of guaranteed salary, productivity payments, and a portion of shared savings and/or separate quality-based bonuses
- Quality metrics are often used to establish eligibility for some or all of an ACO's potential shared savings, but are not generally used to pay separate quality bonuses if no savings are achieved
- Note that "quality" in this construct typically includes clinical processes and outcomes as well as other measures of provider performance such as patient satisfaction surveys

In most shared savings arrangements a Minimum Savings Rate (MSR) establishes the degree of savings an ACO must achieve in order to be eligible to earn any amount of savings. An MSR is used to ensure that ACOs only share in savings that are statistically significant and don't result from random variation in expenditures. For example, an MSR of 1% would require that the ACO's actual costs at the end of the performance year are at least 1% lower than the expected cost benchmark in order for the ACO to share in the savings.

The MSR set in a contract often depends on the size of the ACO (i.e. the number of lives the ACO manages) and the contract type (i.e. upside vs. two-sided risk). Random variation is less likely in a larger population and thus will usually be accompanied by a lower MSR (Bailit & Hughes, 2011). The MSR used by CMS ranges from 2.0% to 3.9% depending on the size of the beneficiary population. A 2.0% MSR is used for ACOs with greater than 60,000 patients. 3.9% is the highest MSR and is applied to ACOs with 5,000 patients, the minimum population required for participation in a CMS MSSP (CMS, 2014). Some payers believe that random variation will occur in both directions (i.e. result in savings and losses) and even out over the contract period. For this reason some payers do not utilize an MSR and others utilize a very low MSR regardless of population size. A lower MSR generally makes a shared savings contract more appealing to an ACO.

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### ***Upside vs Two-Sided Risk:***

A shared savings contract can have only an upside or can have an upside and a downside. In an upside-only contract the ACO will have the opportunity to share in savings if actual costs are below the expected cost benchmark, but will not be at financial risk if costs are in excess of the cost benchmark. In a contract that has upside and downside risk (also known as two-sided risk) the ACO will continue to have an opportunity for savings, but will also incur a loss if spending is higher than the expected cost benchmark. The loss will occur in the form of a payment back to the payer for costs that exceed what was expected. Similar to an MSR, in a downside arrangement there is a threshold of excessive expenditures that has to be met before the ACO incurs a loss. This is known as a Minimum Loss Rate (MLR). ACO expenditures must be in excess of the MLR for the ACO to be required to owe the payer for the costs beyond what was expected. In both the MSR and the MLR the amount of savings and/or losses are capped at a maximum amount.

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CMS is considering the use of a deferred reconciliation for MSRs. In this scenario the MSR would be applied over an entire contract period, so if the ACO achieves consistently small savings each year that cumulatively reach the MSR, those savings will be shared at the end of the contract period (Gaus, 2015).

Three contract design features figured in the EAC’s discussions about the potential for payment calculation to impact under-service or patient selection:

Contract Design Feature	Common Design Options
<i>Does the contract type use downside risk, or upside risk only?</i>	<ul style="list-style-type: none"> <li>• In a downside risk arrangement the maximum share of savings an ACO can earn is usually set at a higher percentage to make participation in a downside risk arrangement more appealing; greater risk, greater reward.</li> </ul>
<i>Does quality performance affect the ACO’s opportunity to earn savings?</i>	<ul style="list-style-type: none"> <li>• The majority of programs define a quality threshold that must be met to receive any savings.</li> <li>• In a <u>varied</u> arrangement the percentage of savings given to the ACO correlates with quality performance. Better quality performance relative to peers or over the prior year will result in a higher percentage of savings earned by the ACO.</li> <li>• In a <u>fixed</u> arrangement the amount of savings shared with an ACO remains the same as long as the minimum threshold for quality performance is met.</li> </ul>
<i>How is quality performance measured?</i>	<ul style="list-style-type: none"> <li>• Quality performance of an ACO can be evaluated as it compares to the performance of other ACOs. This is commonly called a <u>benchmark</u> method.</li> <li>• Quality performance can also be measured based on an ACO’s <u>improvement</u> over the prior year.</li> <li>• Some arrangements use a combination of the benchmark and the improvement methods</li> <li>• The improvement method helps to engage lower performers and likely will account for any risks inherent in the ACO’s population that might make achievement of a benchmark difficult</li> <li>• A benchmark method can be useful for high performers for which demonstrating further improvement may be difficult.</li> </ul>

References for table: (Bailit & Hughes, 2011; CMS, 2014)

Most shared savings contracts require that an ACO meet minimum thresholds on a set of quality measures in order to be eligible to receive a portion of the savings achieved. However, other payment arrangements also exist that will provide incentive payments independent of one another; one incentive payment for the achievement of quality targets and another incentive payment for the achievement of savings (Bailit & Hughes, 2011; McGinnis, Riley, Zimmerman, & Sahni, 2013).

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#### Example: CMS Medicare Shared Savings Program (MSSP) Payment Calculation

The maximum shared savings payment for ACOs ranges from 50% to 75% of total savings achieved. The opportunity varies depending on the type of contract. Upside contracts have a maximum savings opportunity of 50% while downside risk contracts have a maximum savings opportunity from 60% to 75%. The ACO's maximum share is greater for contracts that require greater downside risk.

CMS assesses MSSP ACOs' quality using a benchmark. An ACO's performance is ranked against all other Medicare providers' performance based on a percentile ranking. The ACO is required to meet a baseline level of performance on a select set of quality measures to receive any share of savings it generates. The share of savings given to the ACO is based on a sliding scale using a point system. Points are assigned to an ACO for each quality measure based on its percentile performance. An ACO that earns the maximum number of points will receive the maximum amount of savings (i.e. 50% for an upside only contract).

Reference: CMS Fact Sheet, CMS quality methodology

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Once the savings are received by the ACO, the ACO is responsible for distributing the savings to the provider participants in the ACO. Most ACOs consider at least three questions when deciding how to distribute savings amongst participants:

1. Should the ACO retain a portion of the savings?
2. How should money be distributed among ACO participating organizations?
3. What factors should play a role in how savings are distributed to individual providers?

Often an ACO retains a portion of the savings to support the infrastructure needed to run the ACO. ACOs that are in a downside risk arrangement or are considering moving to a downside arrangement from an upside only arrangement will take a portion of the savings to build a reserve fund. The composition of ACOs varies greatly, from having primary care providers only to having primary care providers, specialists, hospitals, and providers of other services along the care continuum (e.g. skilled nursing facilities). How the savings are distributed between these groups usually takes into consideration the centrality of the role each provider type plays in managing the quality and cost of care for attributed patients.

Lastly, individual providers may receive a portion of the savings – but the savings may be pooled by the provider group and distributed in any number of ways. Individual providers' shares can be based on how many attributed patients they cared for, their individual quality performance, or their individual contribution to achieving the savings. A common method for determining an individual provider's share of the savings involves using quality performance and weighting by the number of patients attributed to that provider (The Chartis Group, 2014).

## Discussion

The way in which payments are calculated and distributed will affect the nature and mix of financial incentives that ACOs and individual providers face. Unlike other aspects of shared savings payment design (e.g. attribution, cost benchmarking), payment calculation and distribution design are heavily related to performance on quality. The incentive to improve quality in these types of arrangements serves as an important complement and counterbalance to incentives to lower costs. While in many cases, delivering higher-quality care will inherently reduce total medical expenditures – especially over a long period of time – in other clinical scenarios higher-quality care may be higher-cost care. Accordingly, incorporating a strong financial incentive to maintain and improve quality is generally recognized as an important safeguard against under-service in total cost of care payment arrangements.

Financial incentives to improve quality can be established through the use of a quality threshold. A quality threshold will require that baseline quality performance is achieved, either as compared to others or to one's own performance, in order to be eligible for any savings (Bailit & Hughes, 2011).

**Recommendation # 1: ACOs should only be able to share in savings if they meet threshold performance on quality measures.**

Though the use of a quality threshold provides a built-in under-service safeguard, there are shared savings programs that make cost management incentives distinct from quality incentives. In these models an ACO can receive shared savings without improving quality and, conversely, can be rewarded for quality without achieving savings. In the former scenario, to protect against ignoring quality, the amount of savings received is usually correlated with quality performance, despite the absence of a threshold (McGinnis, Riley, Zimmerman, & Sahni, 2013). In the latter scenario, ACOs will be rewarded for quality regardless of savings achieved, which may reduce the incentive to stint on care in order to hit cost benchmarks and earn savings.

**Recommendation # 2: Providing discrete incentive payments based on quality performance, irrespective of whether savings are achieved, will promote the provision of appropriate care and serve as a counter-balance against any incentive to inappropriately reduce costs.**

The manner in which quality performance is measured and used to calculate an ACO's shared savings opportunity are additional factors that impact the incentive to improve quality. Assessing quality performance in a manner that is perceived as fair, and scaling the opportunity for savings with improved performance, will provide greater incentive for providers to focus on quality improvement.

To assess quality performance fairly, payers should consider methods to control for clinical and socioeconomic factors that may impact quality performance. Assessing quality performance based on an ACO's improvement over the prior year inherently accounts for the clinical and socioeconomic factors associated with that ACO's patient population. In contrast, comparing an ACO to its peers to assess performance, absent any adjustment, may not account for the relative complexity of their patients and may put an ACO with more complex patients at a disadvantage.

Within the context of a method that rewards improvement, quality goals that are unique to each ACO can be established with the intent of providing a greater reward for greater improvement. Providing individual ACOs with threshold, target, and stretch goals, with performance between these goals scaled to correlate with increased savings opportunity, will encourage continual quality performance

improvement. The combination of assessing quality performance based on improvement, with varied improvement targets that are unique to the ACO, will encourage ACOs with quality performance across the spectrum (i.e. both high and low performers) to participate in shared savings arrangements and continually strive toward better quality performance.

**Recommendation #3: ACO quality goals should be based, at least in part, on an ACO's prior performance, and should contain a range of goals (i.e. threshold, target, and stretch). By correlating the opportunity to earn savings with quality performance, increasing the share of savings the ACO receives on a sliding scale based on quality performance between their own threshold and stretch goal, payers can incent a pattern of continuous performance improvement.**

Successful ACOs generally make investments to build the infrastructure that supports the care management and clinical decision-making required to become more cost-efficient and improve quality (Lewis, Larson, & McClurg, 2012). CMS recognized that this can be a challenge, especially for smaller organizations, and led to the development of two different ACO models that provide funding at the start of the ACO contract: the ACO Investment model and the Advance Payment ACO model (CMS, Innovation Models, 2015).

Because of the degree of investment required to be a successful ACO, these organizations may experience financial pressure to recoup the cost of these investments through new revenue streams, including shared savings. In this sense, even upside-only contracts may generate “risk” for ACOs in the form of pre-paid investments. This type of financial incentive is a potential driver for the sort of potential activities – under-service and patient selection – that the EAC has been asked to assess. Accordingly, the EAC considered ways in which pressure to hit financial targets could be minimized without undermining the incentives to manage costs in appropriate ways.

The MSR is one design feature that can be adapted to this end. As mentioned above, some ACOs have ceased to use an MSR or are considering deferring MSR reconciliation to eliminate and/or diminish the hurdle it presents to achieving savings (Bailit & Hughes, 2011; Gaus, 2015).

**Recommendation #4: MSRs should not be utilized, or should be structured in a way that allows for deferred recoupment of savings. In the former case, any savings achieved should be shared with providers (assuming quality thresholds are met), thereby reducing the “all or nothing” aspect of reaching or not reaching an MSR. In the latter case, if an ACO demonstrates savings over a multi-year period which failed to meet an MSR in individual years, but which in combination are statistically significant, the ACO should be retroactively eligible to share in those savings.**

The EAC considered additional design features related to the use of savings not traditionally retained by ACOs that might promote equity and access. An ACO that is struggling to meet quality targets, and therefore will not receive any share of savings that it generates, might be struggling to meet targets in part due to gaps in its infrastructure. Using a portion of the savings an ACO achieves – but does not retain – to invest in infrastructure that promotes quality of care could help lift under-performing ACOs and ensure that they continue on an improvement path rather than exit the shared savings program.

**Recommendation #5: When an ACO demonstrates cost savings, but is not eligible to receive the savings (either because the MSR was not met or because quality/performance targets were not met), the funds should be reinvested either (a) into the community's delivery system as a whole or (b) into the ACO (subject to a set of guidelines to ensure that funds are earmarked to support the ACO's future ability to deliver high performance, and are not used to finance incremental growth or compensation)**

Thus far, this report's discussion has concerned payment design incentives faced by ACOs. It has not discussed incentives faced by provider groups or individual providers. Payment distribution is the sole design feature related to shared savings arrangements that has a direct financial impact on a provider group (assuming it is not the sole participant in an ACO) or on an individual provider (i.e. it will affect the provider's take-home pay).

Choices about payment distribution will affect whether and how any of the incentives faced by an ACO are passed through to successively lower, more disparate levels of the delivery system. Accordingly, those choices will have implications for the necessity and appropriateness of various other safeguards. For example, if any financial incentives to stint on care or select against high-risk patients begin and end at the ACO level, then arguably that is the level of activity at which monitoring activities should be focused. Conversely, if provider groups or individual providers are rewarded for managing their own patients' cost of care – rather than for the ACO's overall cost performance – then monitoring arguably needs to extend equally to the provider group or individual provider level.

By keeping the incentive to become more cost efficient at the level of the ACO or the provider group, rather than extending it to the individual provider, it is more likely that cost efficiencies will come from providers working together to manage utilization effectively, and not from inappropriate under-service. In addition, this arrangement potentially makes the task of monitoring substantially more efficient and effective by permitting it to focus on a relatively small number of ACOs, or even provider groups, rather than on a relatively large number of individual providers. In this scenario, provider groups and individual providers will still have an incentive to manage costs efficiently, since the total savings available to distribute are based on the ACO's overall cost performance. But if the portion of the ACO's savings that a group or a provider earns is based on something other than its own patient panel's cost savings (i.e. on a combination of quality and number of attributed lives), then the financial benefit of inappropriately reducing costs will be distributed and diluted across the group, while the risk of inappropriately reducing costs (i.e. from oversight by the group, the ACO, the payer, and licensing bodies) will remain squarely on the provider. This type of structure is a potentially powerful counter-incentive to under-service and patient selection.

**Recommendation #6: To reduce the incentive for providers to under-serve in order to generate savings, provider groups at the sub-ACO level and individual providers should not be rewarded based on the portion of savings they individually generate. Rather, provider groups and individual providers should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel.**

## Summary of Recommendations:

**Recommendation # 1:** ACOs should only be able to share in savings if they meet threshold performance on quality measures.

**Recommendation # 2:** Providing discrete incentive payments based on quality performance, irrespective of whether savings are achieved, will promote the provision of appropriate care and serve as a counter-balance against any incentive to inappropriately reduce costs.

**Recommendation #3:** ACO quality goals should be based, at least in part, on an ACO's prior performance, and should contain a range of goals (i.e. threshold, target, and stretch). By correlating the opportunity to earn savings with quality performance, increasing the share of savings the ACO receives on a sliding scale based on quality performance between their own threshold and stretch goal, payers can incent a pattern of continuous performance improvement.

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