

The EAC considered additional design features that might promote equity and access related to the use of savings not retained by ACOs.

The need for safeguards against under-service and patient selection in a shared savings environment presupposes that, absent such safeguards, an ACO could conceivably reduce healthcare costs and achieve quality targets, thereby earning shared savings, despite (or perhaps owing to) stinting on appropriate care or inappropriately restricting access to its patient panel.

One safeguard against this unwanted result is the adoption by payers of a rule that disqualifies an ACO found to engage in under-service or patient selection from earning any shared savings it achieves during the performance period in question (see Recommendation 3.1). Such a rule, if adopted, begs an additional question: what happens to the savings that the ACO achieved?

In isolation, the rule's practical effect is that the savings accrue to the payer. The EAC contemplated alternate uses of these funds which could be implemented via provisions in the contracts entered into between payers and ACOs. Specifically, it suggested that the savings should be reinvested in the community's delivery system, in a way that helps ACOs attain the desired level of performance and rectify problems that may otherwise lead to under-service or patient selection as follows:

Recommendation #3.5: Reinvestment of Non-Retained Savings. When an ACO demonstrates cost savings, but is not eligible to receive the savings because it was found to have stinted on care or inappropriately discontinued patients, the funds should be reinvested in the community's delivery system via an independent entity that administers the funds and ensures that they are earmarked to support improvements in access and quality.

The EAC undertook extended deliberation on the topic of non-retained savings. [After long discussions, in a meeting that included insurer/payer representatives, providers, consumers and state agency](#)

representatives, the committee reached consensus on the modified language recommendation. Subsequently however, representatives from Aetna, United Healthcare and Anthem consulted with others and decided to oppose the recommendation, forcing a non-consensus finding.

During the deliberations members expressed a number of perspectives about why this type of practice might or might not be beneficial or practical. The principal rationales for adopting the recommendation were as follows:

□ **Reinvestment of non-retained savings provides an additional source of funds to invest in ~~much-needed provider infrastructure that supports the transformation of care delivery to be more patient-centered~~improving quality and value.** While this rationale is principally related to objectives other than preventing under-service or patient selection, it does bear on those topics. Consumers and taxpayers paid for the care expecting value for their spending. Ensuring that savings generated by underservice or patient selection are invested back into quality improvement honors the original purpose of their spending. As asserted in Recommendation 3.6, “ACOs that have sufficient infrastructure will be more likely to lower costs through effective care management and less likely to lower costs by stinting on care or discontinuing patients.” This rationale requires a less restrictive set of conditions concerning use of reinvested funds than does (1) above.

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□ **Reinvestment of non-retained savings is essential to prevent payers from intentionally inducing under-service in order to withhold and keep shared savings payments. Payers**

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should not profit from underservice, nor should they have any incentive to cause it. Absent reinvestment of non-retained savings, when a payer finds that an ACO has engaged in under- service or patient selection, the payer reaps twice the reward from the ACO's efforts than it otherwise would. A payer could intentionally act to make this more likely. For example, it could establish burdensome prior authorization rules which dissuade providers from even asking for authorization for certain kinds of services, and then use the failure to provide those services as the basis for a finding of under-service (providers will not necessarily know in advance what criteria a payer will use to monitor for under-service, a concept the Council has endorsed in the interest of promoting the effectiveness of monitoring methods). The payer's purpose in adopting such a practice would be to increase the chances that the savings going to the provider instead go to the payer. Prior authorization is among other tools already used by payers to save money in this fashion; under the shared savings model, the providers can also be enlisted in this effort through the financial incentives to propagate these kinds of inappropriate restrictions on access to care.

□ Denial of inappropriately-derived shared savings from both payers and ACOs will prevent rare future occurrences.

The proponents of the recommendation agree that, especially in the current early stages of accountable care adoption, this scenario is likely to be rare. Payers are now actively recruiting and supporting provider groups to create ACOs and accept financial risk, and are unlikely to engineer underservice or patient selection to garner double savings payments. However as the market shifts over time, as it did in the 1990's under managed care, this may change. This recommendation is designed to prevent inappropriate behavior. As it is generally agreed that this will be a rare event, adoption of the recommendation should present no burden to payers or ACOs.

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Investment in independent quality improvement ensures that inappropriately non-retained savings are not re-directed to ACOs.

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Because many ACOs are now developing, or considering developing, their own insurer business, returning denied savings to insurers could end up benefitting the ACO that stinted on care, contrary to the premise of this Council and the SIM final plan.

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Reinvestment of non-retained savings constitutes an effective vehicle for returning resources to consumers who were affected by the under-service or patient selection. The cost of health plan premiums is ultimately borne by enrollees and taxpayers; earmarking a portion of unspent premiums (which take the form of savings against a benchmark spend) through an independent entity for tangible improvements to care delivery assets provides a way to use the funds for the benefit of communities, fostering value-based purchasing and supporting SIM's goals.

Reinvestment of non-retained savings ~~will~~ could reduce under-service and patient selection by directly funding interventions to mitigate the underlying behavior. This ~~rationale recommendation~~ would ~~require that~~ allow non-retained savings ~~are earmarked to provide assistance~~ specifically for those organizations found to have stinted on care or inappropriately discontinued patients, and are further earmarked for specific, payer-sanctioned uses that remediate the identified issues. ~~ACOs would be prohibited from using the funds for general purposes. There are several enforceable mechanisms to ensure that the funds would not indirectly benefit the ACO, for instance a maintenance of effort on quality spending contract requirement.~~ —

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The principal rationales for not adopting the recommendation were

as follows:

□ **Reinvestment of non-retained savings may not be consistent with the reasons for which payers and self-funded employers participate in value-based payment arrangements such as shared savings.** In addition to reducing the total cost of care for payers, ~~t~~he intent of these ~~organizations programs~~ is to use shared savings payments to incent and reward providers that demonstrate value in the form of quality and efficiency; it is not to finance infrastructure upgrades for organizations that violate the program’s intent or otherwise fail to demonstrate value. Payers and self-funded employers are unlikely to support use of a contract provision that calls for reinvestment of non-retained savings as evidenced by their strong opposition to this recommendation.

— □ **Reinvestment of non-retained savings, to the extent it is intended to prevent payers from gaming the system in the manner described ~~in (3)~~ above, constitutes a solution for a problem that is highly unlikely to arise.** ~~If a payer were found to be augmenting profits by deliberately inducing an ACO into failing a test for under service, it would likely be subject to civil and perhaps criminal sanctions. In addition, ~~t~~~~his type of activity would undermine the payers’ ~~own~~

~~work~~self-interest, under current market conditions, to promote the use of shared savings arrangements. ACOs found to have stinted on care ~~are~~ may ~~less~~be less likely to reenroll in the program, and if they do, they are likely to be needlessly and overly conservative in their approach to managing inappropriate costs.

Commented [EA1]: This is clearly false. The opponents need to offer evidence to support this inflammatory statement. Underservice happens frequently now, even without shared savings. It is the entire premise of this Council and these recommendations to avoid the problem.

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