

# Fairness in Shared Savings Distribution: The Elephant in the ACO Waiting Room

Stephen Sheiko, CF APMP  
Craigian Gray, MD, MBA, JD







# Table of Contents



## **1** Fairness in Shared Savings Distribution: The Elephant in the ACO Waiting Room

pg.2



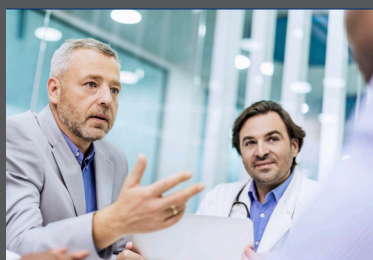
## **2** Fairness: The *Sine Qua Non* of Shared Savings Distribution

pg.4



## **3** Apples to Apples: No Fairness Without Risk Adjustment

pg.6



## **4** Transparency: The Flip Side of the Fairness Coin

pg.10

# Fairness in Shared Savings Distribution: The Elephant in the ACO Waiting Room

On August 25, 2015, the Centers for Medicare and Medicaid Services (CMS) released 2014 performance year final results for its two principal Accountable Care Organization (ACO) programs, the Pioneer ACO and the Medicare Shared Savings Program (MSSP). For 2014, 92 out of 333 ACOs in the MSSP—by far the larger of the two programs—achieved savings beyond the minimum threshold and qualified for shared savings payments from the program. This represented a significant increase over the prior year, when 58 ACOs achieved shared savings.<sup>1</sup> We can safely assume that this trend will continue as more ACOs join the MSSP and existing ACOs mature and grow in capability to reduce costs and improve quality. Consequently, over the next several years, more and more ACOs will be faced with the question: how should shared savings payments be distributed among our stakeholders?

While CMS requires ACOs to submit a shared savings plan in their initial application to the MSSP and to publicly report their distribution plans on their websites<sup>2</sup>, a recent study showed that the level of detail reported varied widely—while nearly 85% of ACOs provided at least basic information about their distribution plans, only about half disclosed planned percentage distributions to providers within the ACO.<sup>3</sup> Moreover, CMS itself provides

little guidance on how shared savings should be distributed<sup>4</sup> beyond stipulating that any plan should be consistent with the program's overall mission.<sup>5</sup>

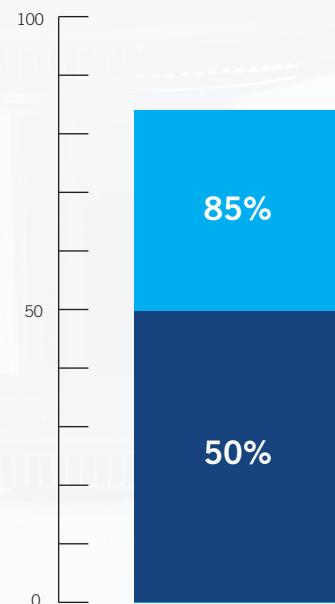
Despite this lack of definitive guidance from CMS and relative paucity of details from most ACOs, the importance of shared savings distribution plans should not be underestimated. The uncertainty inherent in beneficiary attribution poses a very real risk to ACOs' stability and viability, and provider turnover has the potential to impact an ACO's attributed population at a scale far greater than patient compliance and engagement do. This fact, along with the very nature of the MSSP as a pay-for-performance program, makes recruiting and retaining quality providers a task of paramount importance for ACO success.<sup>6</sup> As providers determine whether to join an ACO—and in progressive or competitive markets, choose among multiple ACO suitors—one of their key considerations will be the ACO's shared savings distribution methodology.<sup>4,7</sup> "ACOs must offer a realistic and achievable opportunity for providers to share in the savings created from delivering higher-value care. The incentive system must reward providers for delivering efficient care as opposed to the current volume-driven system."<sup>8</sup>

27% of ACOs in the MSSP qualified for shared savings payments from the program in 2014





Nearly 85% of ACOs provided at least basic information about their distribution plans, only about half disclosed planned percentage distributions.



More and more ACOs will be faced with the question:  
How should shared savings payments  
be distributed among our stakeholders?

# Fairness: The Sine Qua Non of Shared Savings Distribution



Rather than advocating for a discrete shared savings distribution methodology, we have elected to focus on the singular aspect of savings distribution formula development—fairness—without which any such formula is doomed to failure. While various shared savings distribution models have been proposed since the inception of the MSSP, the consensus view is that no single model will meet the needs of all ACOs. Specifics of an ACO's distribution plan necessarily will depend upon the composition of the ACO (e.g., does it include specialists or only primary care providers? Is there a hospital participant? Etc.) and the organization's maturity and capabilities. In fact, the Toward Accountable Care (TAC) Consortium recommends that the savings distribution formula constantly evolve, adapting and improving as the ACO becomes more experienced and adept in managing the care and health of its population.<sup>7</sup>

Multiple commentators cite fairness as a best practice in shared savings distribution<sup>4,7,9</sup>. While fairness has been identified in these contexts as one among several guiding principles or best practices in shared savings distribution, we contend that it is in fact *the single most important aspect* of a successful plan. It is widely acknowledged that recruitment and retention of high-performing providers is essential to the success—indeed, the survival—of ACOs. That task, we believe, will prove impossible unless ACOs can demonstrate to their provider partners that they have a specific and realistic plan for fairly distributing the shared savings achieved by the providers working in concert under the ACO umbrella to improve the quality of patient care. One physician quoted by the TAC Consortium concisely summarized our view: “No physician is going to join an ACO when someone else is telling them what they are worth unless they know that the savings distribution formula is impeccably fair.”<sup>7</sup>

“No physician is going to join an ACO when someone else is telling them what they are worth unless they know that the savings distribution formula is impeccably fair.”





# Apples to Apples: No Fairness Without Risk Adjustment



As we have observed, no single “one size fits all” shared savings model can meet the needs of every ACO; indeed, as ACOs grow, change, and mature over time, their savings distribution models will likely require adjustment. DeCamp et al. have proposed in the *Journal of the American Medical Association* five dimensions of distributional fairness that should be considered by ACOs in developing their formulas, yet they acknowledge that “defining a single ‘fair and equitable’ shared savings plan is premature and perhaps impossible.”<sup>9</sup> In this widely varying and fluid context, how realistic is it to identify concrete elements of fairness in shared savings distribution?

We contend that regardless of the specifics of proposed shared savings models—which will invariably differ—one common thread represents an indispensable equalizer for ensuring fairness: **the application of risk adjustment to the attributed population.** Further, applying risk adjustment at the practice or even the beneficiary level will reflect more accurately the micro-populations that influence the attainment of shared savings and the distribution of those savings. Virtually any merit-based shared savings formula will take into account ACO providers’ relative patient population sizes and the total cost of care for those populations. But without risk adjustment—without a way to normalize by patient severity to take account for relative case mixes—such a formula runs the risk of unduly favoring the largest,

highest volume providers without regard for the complexity of care rendered. Indeed, it could inadvertently distort incentives in favor of large providers with relatively healthy populations, especially since those providers may have an easier time driving down costs without negatively impacting population health or quality of care precisely because their patients are healthier initially. At the same time, a non-risk-adjusted formula perversely could discourage from joining ACOs the very providers with the greatest opportunity to impact costs and outcomes—those whose patient cohorts are smaller on account of markedly higher than average complexity that requires more intensive management overall. In any event, without a risk adjustment methodology in place to correct for the varying complexities of patient cohorts across providers, shared savings plans could devolve into disagreements about whose patients are perceived to be sicker and thus requiring more complex care. Only by applying a recognized risk adjustment schema to the attributed population can ACOs truly compare “apples to apples” and accurately determine the relative contribution by their providers, in proportion to which they can then distribute fairly the incentive payments realized by the ACO.

Risk adjustment is not a new concept in payment transformation models such as the MSSP; in fact, CMS uses the Hierarchical Condition Categories (HCC) risk

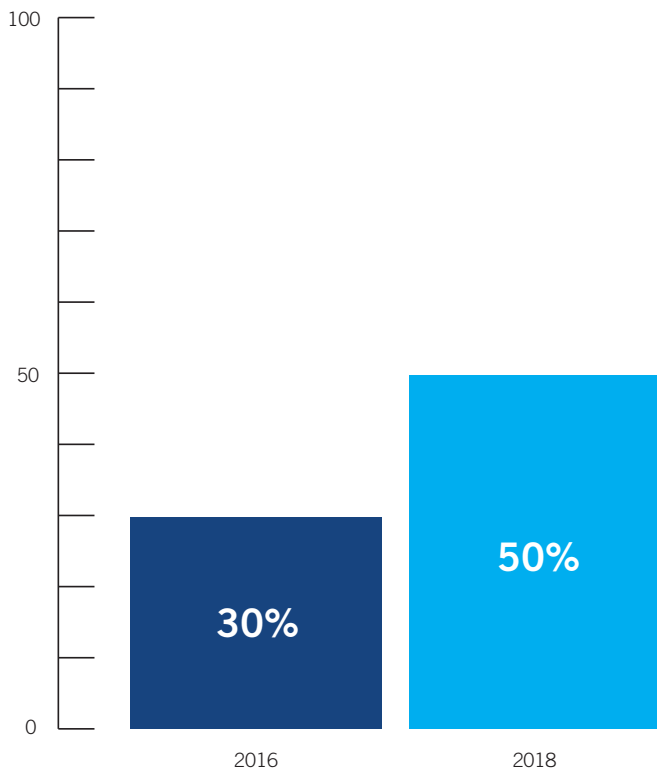
Only by applying a recognized risk adjustment schema to the attributed population can ACOs truly compare “apples to apples” and accurately determine the relative contribution by their providers in order to fairly distribute the incentive payments realized by the ACO.

adjustment model at the attributed population level to adjust each ACO's actual costs according to the population's medical complexity. What we propose then is an extension of CMS's own methodology applied at the individual patient and provider level so that HCCs can be applied on a per-patient, per-provider basis. By continuously applying case-mix adjustments to the ACO's population and its constituent micro-populations—the patient cohorts of member providers—according to the same specification that CMS uses to evaluate the ACO as a whole, the ACO can gauge accurately the performance of its providers on cost, quality, and other performance metrics on an ongoing and up-to-date basis. It is clear now that by furnishing the same data to member providers, the ACO can mitigate the risk of unpleasant surprises and year-end protestations that “my patients were sicker than yours!”

Looking ahead, as healthcare reform continues to evolve and shift away from volume-based reimbursement, risk adjustment will continue to grow in importance. CMS has

already announced its intentions in this regard, setting a goal of tying 30 percent of fee-for-service Medicare payments to value-based alternative payment models (including ACOs) by the end of 2016, a figure set to rise to 50 percent by the end of 2018.<sup>10</sup> Seen in this context, shared savings represents an early retrospective precursor to more advanced value-based payment mechanisms in the future. By effectively utilizing risk adjustment methods such as HCC and incorporating them into their shared savings distribution models, ACOs position themselves for success in the next round of value-based payment initiatives by increasing their capacity to understand, accept, and manage risk.

For these reasons, we believe that any ACO shared savings distribution formula that does not incorporate risk adjustment at the individual provider level simply cannot provide a truly fair, equitable, and forward-looking formula for rewarding providers' true relative contributions to the success of the ACO as a whole.



The goal: tying 30% of fee-for-service Medicare payments to value-based alternative payment models by 2016 and rising to 50% of payments by 2018.







# Transparency: The Flip Side of the Fairness Coin



Like fairness, transparency is mentioned frequently as an indispensable aspect of an ideal shared savings distribution plan.<sup>4,7</sup> CMS requirements to disclose shared savings distribution plans in ACOs' initial applications and subsequently to report those plans on their public websites reinforces the importance of this principle.<sup>2,5</sup> While such transparency could be interpreted as applying to the shared savings methodologies themselves (i.e., full disclosure of the formulas by which savings will be distributed), we believe that it must go a step further. Few medical practices will have the analytical capability or information technology (IT) infrastructure to continuously monitor their own quality and cost performance, let alone apply risk adjustment methodologies to these measures to normalize for case mix. Therefore, we contend that ACOs must not only share their incentive distribution formulas with their providers, but must actually make the underlying data and calculations available to them on an ongoing and updated basis. Beyond taking transparency to the next level, this data and analytics sharing, in fact, constitutes a necessary element of fairness. Without providing continuous and reliable visibility into the true metrics upon which the ACO's providers will be evaluated—which, as we have argued above, must include risk adjustment—the ACO cannot claim fairness in its methodology in any meaningful sense.

Transparency, moreover, encompasses far more than simply allowing providers in the ACO to see and manage their patient population according to their true cost of care, i.e., as normalized via risk adjustment. Providers need visibility into the full spectrum of metrics by which their success within the ACO is measured. Patient satisfaction, access to care, internal measures such as participation in provider meetings, and quality metrics such as GPRO—all have a role to play in how the ACO is evaluated and, by extension, how the ACO evaluates its providers as expressed by their sharing in savings achieved. Transparency also requires

that providers be able to keep tabs on patient attribution status, monitoring proper coding as well as flagging patients in danger of dropping out of the attributed population.

By maintaining the infrastructure to provide a “single version of the truth” and furnishing it to its providers, the ACO truly adds value to the healthcare ecosystem—facilitating the pursuit of the Triple Aim rather than becoming yet another middleman in an already complicated environment. This value-add opportunity also allows ACOs to differentiate themselves as they seek to recruit and retain high-performing providers.

Our first paper in this series, “Choosing the Right Performance Management System for your ACO”, provides further details on the essential aspects of such a system.

As MSSP ACOs continue to grow and mature, more and more will achieve shared savings. The question of how those savings will be distributed will therefore become increasingly important and urgent. Despite little concrete guidance from CMS, ACOs must consider a robust shared savings distribution methodology as a key differentiator in attracting and retaining quality providers. While no “one size fits all” model exists, any model must, at its core, be fair—accurately measuring the relative contributions of providers toward the ACO's overall goals. We contend that in order to truly achieve this fairness, ACOs must incorporate risk adjustment methodologies into their metrics. Risk adjustment solves for the variations in case mix across providers and allows for a normalized comparison of performance across cost, quality, and other physician performance metrics. Fairness further requires transparency: not only the shared savings distribution formulas, but the underlying data and calculations, must be available to providers so they know how they are evaluated and how they stand against the benchmarks at any given point in time.

The ACO truly adds value to the healthcare ecosystem—facilitating the pursuit of the Triple Aim rather than becoming yet another middleman in an already complicated environment.



## References

1. Centers for Medicare and Medicaid Services. Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014. 2015 [cited 2015 Sep 19]. Available from: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html>
2. Centers for Medicare and Medicaid Services. Medicare Shared Savings Program Public Reporting Guidance, Version 2. 2014 Sep 16; Available from: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Public-Reporting-Guidance.pdf>
3. Schulz J, DeCamp M, Berkowitz SA. Medicare Shared Savings Program: public reporting and shared savings distributions. *Am J Manag Care*. 2015 Aug;21(8):546–553.
4. Redding J. Choosing an ACO: Shared Savings Distribution and Key Questions. *Physicians Practice* [Internet]. 2012 Jun 17; Available from: <http://www.physicianspractice.com/blog/choosing-aco-shared-savings-distribution-and-key-questions>
5. Centers for Medicare & Medicaid Services (CMS), HHS. Medicare program; Medicare Shared Savings Program: Accountable Care Organizations. Final rule. *Fed Regist*. 2011 Nov 2;76(212):67802–67990.
6. Siddiqui M, Berkowitz S. Shared Savings Models for ACOs- Incentivizing Primary Care Physicians. *J Gen Intern Med*. 2014 Jun;29(6):832–834.
7. Toward Accountable Care Consortium. Distribution Based on Contribution: A Merit-based Shared Savings Distribution Model [Internet]. Raleigh, NC: Toward Accountable Care Consortium; 2013. Available from: [http://www.tac-consortium.org/wp-content/uploads/2013/04/Physician\\_ACO\\_Toolkit\\_NC.pdf](http://www.tac-consortium.org/wp-content/uploads/2013/04/Physician_ACO_Toolkit_NC.pdf)
8. Engleberg Center for Health Care Reform, Dartmouth Institute. ACO Toolkit [Internet]. Washington, DC: Brookings; 2011. Available from: <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>
9. DeCamp M, Sugarman J, Berkowitz S. Shared savings in accountable care organizations: how to determine fair distributions. *JAMA*. 2014 Mar 12;311(10):1011–1012.
10. Burwell SM. Setting Value-Based Payment Goals - HHS Efforts to Improve U.S. Health Care. *N Engl J Med*. 2015 Jan 26;

As MSSP ACOs continue to grow and mature, more and more will achieve shared savings. The question of how those savings will be distributed will therefore become increasingly important and urgent.

## About Salient

Salient Management Company offers business and government a new solution for efficient management. Drawing on diverse data from multiple sources, Salient technology measures how business activity creates value, quality, financial efficiency, and productivity, while the user interface eliminates barriers to using this knowledge for continuous process improvement.

Salient is a worldwide provider of advanced performance management and decision support systems for a wide range of industries and the public sector. Founded in 1986, Salient today serves more than 450,000 users in 66 countries.

### **Contact us for a demonstration:**

phone 607.739.4511

email [healthcare-info@salient.com](mailto:healthcare-info@salient.com)