Since the turn of the century, the health care system in the United States has shifted focus to reform the delivery and payment systems in response to challenge to increase access, decrease costs, and improve quality of care. Through the beginning of 2008, 160 pay-for-performance (P4P) programs had been implemented in the United States,\(^1\) and in March 2010, the U.S. Congress passed the Patient Protection and Affordable Care Act (PPACA or ACA),\(^2\) establishing health care delivery and payment system reforms intended to increase quality and curb costs. Reforms focusing on reducing hospital acquired infections and preventable 30-day readmissions, as well as implementing the value-based purchasing program and the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs), were but a few reforms designed in part to maintain the financial viability and integrity of government health care programs.

As of January 2013, nearly three years since the enactment of the ACA, 250 ACOs were enrolled in the MSSP or the Premier ACO programs, and this number does not include purely commercial ACOs not enrolled in the MSSP or Premier. ACOs take on many forms, including hospital/physician joint ventures, physician-owned ACOs, health plan/provider ACOs, and retail pharmacy-owned ACOs, just to name a few models. With the wide ranging structural considerations that accompany ACO formation and operation, among the most perplexing questions faced by ACOs developers is how to distribute shared savings to ACO participants, and ACO regulations give little guidance on this topic.

**WAIVERS**

Given the current regulatory environment restricting payments for physician referrals and related increases in enforcement activity and publicity, ACO developers have been justifiably concerned about how distributions of shared savings to physicians would be interpreted by various regulatory bodies. The Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) of the Department of Health and Human Services gave some degree of welcomed flexibility, most notably through the issuance of various regulatory waivers. However, with such waivers, questions still remain regarding proper methods for distributions of shared savings by ACOs.

In lockstep with the November 2011 issuance of the Final Rule\(^3\) for ACOs, CMS and the OIG released an Interim Final Rule\(^4\) establishing waivers of certain health care fraud and abuse laws specific to arrangements involving

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\(^4\) Id., at 67992.
ACOs participating in the MSSP. The five waivers apply uniformly to ACOs, ACO participants and ACO provider/suppliers, and are self-implementing, meaning participating parties are not required to apply for individual approval. The waivers were well-received, given fears that without any relief from current regulatory burdens, compliance would be too restrictive and possibly prevent the development of ACOs, thus undermining the goals for the MSSP.

One such waiver is the Shared Savings Distribution Waiver. Under this waiver, the Stark law, Federal anti-kickback statute (AKS), and the gainsharing civil monetary penalties law are waived with respect to the distribution or use of shared savings earned by an ACO, provided all of the required conditions are met, most notably that the shared savings are used for activities reasonably related to the purposes of the MSSP (emphasis added). Following are the requirements of the Shared Savings Distribution Waiver:

- The ACO has entered into a participation agreement and remains in good standing under its participation agreement;
- The shared savings are earned by the ACO pursuant to the Shared Savings Program;
- The shared savings are earned by the ACO during the term of its participation agreement, even if the actual distribution or use of the shared savings occurs after the expiration of that agreement;
- The shared savings are:
  - Distributed to or among the ACO’s ACO participants, its ACO providers/suppliers, or individuals and entities that were its ACO participants or its ACO providers/suppliers during the year in which the shared savings were earned by the ACO; or
  - Used for activities that are reasonably related to the purposes of the Shared Savings Program.
- Payments of shared savings distributions made directly or indirectly from a hospital to a physician are not made knowingly to induce the physician to reduce or limit medically necessary items or services to patients under the direct care of the physician.

While the Shared Savings Distribution waiver is intended to foster flexibility, CMS and the OIG have noted that it should not be difficult for parties to articulate clearly the nexus between their arrangement and the purposes of the MSSP. For this reason it is important that ACO developers be cognizant of this requirement in determining how shared savings are distributed.

\[5\] Id., at 68001.
While CMS and the OIG have provided waivers relative to Stark, the AKS and the Gainsharing CMP, other considerations relative to the distribution of shared savings among ACO participants and providers/suppliers must be considered. First, distribution models, while exempt from the burden of Stark and fair market value (among other things), will still need to be structured as to encourage and motivate physician leadership and participation. A pro-rata type structure, though possibly regulatory sound and easy to administer, will likely de-incentivize physicians from accepting leadership and being at the forefront of and being thought leaders in looking for opportunities to lower costs while providing better care and outcomes for patients.\(^6\)

Interestingly, the ACO Final Rule does not refer to “fair market value” as it relates to shared savings distribution, as CMS and the OIG have attempted to eliminate the burden of fair market value related to the distribution of shared savings. Both CMS and the OIG likely recognized the difficulty (or impossibility) that ACOs would face in distributing shared savings in accordance with fair market value. However, while the fair market value burden may not be necessarily present from a regulatory standpoint in distribution of shared savings in MSSP ACOs, other factors may, at the very least, cause those developing distribution models to consider the rationale and equity behind the distribution method, as discussed below.

**INTERNAL REVENUE SERVICE GUIDANCE**

As the final ACO rules were released, the IRS issued a Fact Sheet\(^7\) with guidance for tax-exempt organizations participating in the MSSP through ACOs. According to the IRS, a tax-exempt may participate in an ACO as long as participation does not result in “prohibited inurement or impermissible private benefit.” The Fact Sheet points to the following five factors\(^8\) that mitigate the risk of impermissible private benefit among tax-exempt participants when ACOs distribute shared savings:

1. The terms of the tax-exempt organization’s participation in the MSSP through the ACO (including its share of Shared Savings or Losses and expenses) are set forth in advance in a written agreement negotiated at arm’s length.
2. CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP.
3. The tax-exempt organization’s share of economic benefits derived from the ACO (including its share of Shared Savings payments) is proportional to the benefits or contributions the tax-exempt


\(^8\) Id., 5-6.
organization provides to the ACO. If the tax-exempt organization receives an ownership interest in the ACO, the ownership interest received is proportional and equal in value to its capital contributions to the ACO and all ACO returns of capital, allocations and distributions are made in proportion to ownership interests.

4. The tax-exempt organization’s share of the ACO’s losses (including its share of Shared Losses) does not exceed the share of ACO economic benefits to which the tax-exempt organization is entitled.

5. All contracts and transactions entered into by the tax-exempt organization with the ACO and the ACO’s participants, and by the ACO with the ACO’s participants and any other parties, are at fair market value.

Not all five factors are required to prevent prohibited inurement or impermissible private benefit. These factors serve as the best guidelines for physician compensation under an ACO that is itself an exempt organization or is comprised of tax-exempt participants, and these should be considered by ACO developers relative to tax-exempt organizations in determining the distribution of shared savings.

PLANNING FOR SHARED SAVINGS MODEL DESIGN

Though waivers are in place to ease the regulatory burden for MSSP ACOs, the ACO Final Rule is all but silent with respect to the use and distribution of shared savings. Not surprisingly, with CMS estimates at approximately $580,000 to start up an ACO and $1.27 million in ongoing annual costs to operate an ACO in the MSSP, the working capital required to start and annually maintain an ACO is substantial, even before distributions can be made to participating providers. Assuming the ACO is successful in generating savings and thereby becomes a recipient of shared savings payments, these funds should first be applied to the operational expense obligations of the ACO, including health information technology costs and care coordination personnel salaries and benefits, for example. In many ACOs, there is little anticipation of any surplus of funds remaining from the shared savings payments received by the ACO after expenses in the early years of operation.

After expense obligations are met and before contemplation of shared savings distributions, ACOs should focus on returns to equity investment by members as first-tier payments. This is an important concept for any investor, but especially critical with private equity firms, for-profit hospital systems, and

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and exempt organizations. It is at this tier that an ACO must determine a market value return to owners based on the assumed level of risk of the investment relative to other investments in the market.

A good number of MSOs in the MSSP propose to return a portion of their shared savings to the organization through reinvestment in infrastructure. A sound business decision in many instances, infrastructure reinvestment allows the ACO to invest in upgraded or enhanced health information system technology to improve capture of fragmented data, perform claims analysis, and enhance reporting. Other ACOs use infrastructure reinvestment to hire additional care coordinators and support staff to enhance patient care and transition, while yet others use infrastructure capital funds to improve facilities. A review of MSSP application summaries posted online by a non-statistical sample of ACOs indicates that the median allocation of shared savings to infrastructure by ACOs reporting reinvestment in infrastructure is approximately 33 percent of the total shared savings distribution.

For the portion of the shared savings distribution destined for participating providers, it is left to the ACO to devise savings distribution methodology. Careful planning, communication, and collaboration among stakeholders are critical to the success of this process, with the overall objective of recognizing the relative contributions of provider classes and individual providers toward ACO shared savings through efficiencies, quality, and performance. Too easily at this juncture, perceptions (real or otherwise) of inequity can derail the process.

**POOLING BY PROVIDER CLASSES**

After covering the organization’s overhead and paying investors, shared savings can be apportioned into pools for provider classes. Some ACOs carve out ancillary services for separate pooling, and others may combine certain provider classes. In general, provider classes are comprised of hospital, primary care, and specialist provider classes. Shared savings available for distribution to participating providers are apportioned to these provider classes in percentages allocated broadly to each provider class, such as the hypothetical example of 30 percent to hospitals, 40 percent to primary care providers, and 30 percent to specialist providers.

A fallacy common among some is the thinking that a larger proportion of shared savings should be attributed to hospital participants in part because of the larger responsibility that hospitals bear in the cost of patient care.
in the inpatient and outpatient settings; however, some weaknesses exist in this argument in many, but not all circumstances. For example, primary care physicians carry a significant level of responsibility for managing the care of the patient and coordinating the movement of the patient along the transition points in the health care system.

The apportionment of shared savings funds to hospital, primary care, and specialist provider pools should consider factors such as the following:

- The ability of the provider class to have an impact on coordinating patient care
- The ability of the provider class to effectively control costs
- The ability of the provider class to successfully manage the care of the patient population and achieve desired clinical outcomes
- The ability of the provider class to effectively coordinate patient transitions and communicate critical patient information across all provider classes

ACOs can create “domains” for measuring performance based on CMS pronouncements or organizational objectives, such as the following:

- Citizenship measures (e.g., communication with other providers)
- Individual performance against performance metrics
- Patient outcomes
- Costs measured against targets

At this juncture, collaboration among stakeholders is essential to ensure fairness. Further, balance is essential - too many measures simply cloud the process, leading to unnecessary administrative complexity, and increased opportunity for failure. When measuring quality, the obvious is to establish benchmarks on which to measure and judge success (or failure). Less obvious are the indirect benefits of meeting a particular benchmark. For example, a hospital that meets objectives of reducing readmissions may experience additional availability for commercial bed-days if previously near capacity.

Within each domain, individual metrics established by the ACO should be simple and easily understood, yet focused on the objectives of meeting the Triple Aim for the population served by the ACO. A starting point for many MSSP ACOs is the set of 33 performance measures established by CMS in the Final Rule, although ACO leaders may employ other metrics specifically applicable to the provider specialty. Examples of these metrics
include Diabetes Mellitus: Foot Exam (NQF 56) and Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation (NQF 84). Optimum measures are best determined through consultation with clinical leadership, provider committees or chiefs of specialty in the ACO.

Also important are financial metrics that are critical to the success of many ACOs. Cost measured on a per-member-per-month basis for total cost of care represents a broad-based metric, while more granular measurements can be made for specifically identifiable services. These can be measured against baseline historical cost data or against actuarially-determined trended cost data for the population to ascertain success or failure of cost controls.

Benchmarking of data and related gap analyses are essential to evaluate the current state of care relative to identified targets in the established domains. Plans to eliminate gaps through established care, transition and communication plans among provider along the fragmented points of care should be implemented and monitored. ACOs that span different regions of the country or treat multiple chronic conditions may find it suitable to subdivide the shared savings by population or condition. Other means of division also exist among large ACOs; these permit the ACO to apply broad shared savings methodology to provider classes at the subdivision level.

**DISTRIBUTING SAVINGS TO PROVIDERS**

Once the net shared savings available for distribution has been determined, there are countless variations that may be devised. The ACO must evaluate each provider's role to ensure that savings are divided in ways that recognize financial and qualitative contributions toward the organization's goals. Importantly, models inside and outside the MSSP cannot violate the "volume or value of referrals" prohibitions of Stark or in any way induce physicians to reduce or limit medically necessary items or services to patients.

Measuring provider quality, cost-savings, and efficiency requires a means for tabulation – in essence, “scorecards.” These differ depending on the provider class and specialty, and can vary among regions, patient population, chronic disease state, or other identified category. For hospitals, measures in some ACOs begin with those recognized by CMS in other delivery and payment reforms instituted by the ACA, such as the hospital value-based purchasing program. These include Surgical Care Improvement Project infection control measures, discharge instruction guidelines, and pneumonia prevention metrics.
For physicians, scoring is often divided between primary care physicians and specialists, with separate pools for each. The proportion of physician shared savings allocable to each pool again varies depending on the relative level of the physician groups to affect cost control, care quality, and care coordination. While specialist care may result in higher overall costs, the ability of the primary care physician or patient-centric medical home to manage costs often results in a greater share of the physician pool apportioned to the primary care pool, sometimes double that of the specialist pool.

Primary care physicians are scored based on financial performance indicators and quality measures, such as those found in the following Aims and Domains established for MSSP ACOs as a whole:

- **Aim: Better Care for Individuals (Patient/Caregiver Experience and Care Coordination/Patient Safety)**
- **Aim: Better Health for Populations (Preventive Health and At Risk Populations)**

The primary care physician “scorecard” should account for the relative weight to be assigned to the financial performance indicators and the individual quality performance metrics that make up the quality measure aims and domains.

How these “scores” are compared among primary care providers can also vary widely among ACOs; again, transparency, simplicity, and understandability are among the keys to maintaining a sense of fairness in the model. These “drivers” can include individual physician scores relative to total physician scores (thus, physicians with the same “score” receive the same value) or other drivers, such as patient member-months, evaluation & management utilization, work relative value units, or other common-denominator measures (physicians with the same “score” receive different values, depending upon patient base size or productivity).

Specialists are regularly scored on specialty-specific metrics. For example, cardiologists may be scored on the following, among others:
Hypertension (HTN): Controlling High Blood Pressure (NQF 18)
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (NQF 68)
Ischemic Vascular Disease: Complete Lipid Panel and LDL Control (NQF 75)
Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (NQF 83)

As with primary care physicians, specialist scoring can vary widely, even within the same ACO among various specialties. As with primary care, financial metrics are often included in specialist measures; however, efficiency, patient and referring physician satisfaction, and specialty-specific quality metrics are critical to specialist shared savings modeling. Drivers can include procedure/case load volume or individual-to-total provider scoring.

The ideal philosophy reflects shared savings models that reward actions of motivated individuals. The measurement tool best suited for an ACO would be one that focuses on quality and cost savings, rather than volume.

CONCLUSION
Designing working models that reward participating providers will continue to be a fluid process; some models will succeed, while others will fail. ACO developers contemplating shared savings methodology will arrive at the destination through flexibility and reasonable returns for stakeholders as ACOs move from infancy to maturity. Not only will ACOs face an uncertain regulatory future apart the MSSP, but similar organizations must also look for ways to distribute earnings and compensate participating providers in ways that promote care coordination, quality, value, and efficiency. A few years of both good and bad will be the ultimate arbiter that decides the models that most effectively achieve the goals of the ACA.