

DISTRIBUTION BASED ON CONTRIBUTION

A Merit-based Shared Savings Distribution Model



ACKNOWLEDGMENT

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County / Regional Medical Societies

Cleveland County Medical Society
Craven-Pamlico-Jones County Medical Society
Durham-Orange County Medical Society
Mecklenburg County Medical Society
Forsyth-Stokes-Davie County Medical Society
New Hanover-Pender County Medical Society
Pitt County Medical Society
Rutherford County Medical Society
Western Carolina Medical Society
Wake County Medical Society

Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of the American College of Physicians
North Carolina College of Emergency Physicians

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North Carolina Council on Child and Adolescent Psychiatry
North Carolina Dermatology Association
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Pediatric Society
North Carolina Psychiatric Association
North Carolina Radiologic Society
North Carolina Society of Anesthesiologists
North Carolina Soc. of Asthma, Allergy & Clinical Immunology
North Carolina Society of Eye Physicians and Surgeons
North Carolina Society of Otolaryngology – Head and Neck Surgery
North Carolina Oncology Association
North Carolina Society of Pathologists
North Carolina Society of Plastic Surgeons
North Carolina Spine Society
North Carolina Urological Association

State Societies / Organizations

Community Care of North Carolina
Carolinas Center for Hospice and End of Life Care
North Carolina Academy of Physician Assistants
North Carolina Community Health Center Association
North Carolina Medical Group Managers
North Carolina Medical Society

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A. Introduction

Our nation is in the midst of an inexorable shift in health care delivery from “pay for volume” to “pay for value.” It is well documented that our current largely fee-for-service system is unsustainable and that a dramatic incentive shift must occur. Every provider needs to be committed to providing the highest quality at the lowest cost. This is the fundamental goal of the pay-for-value system.

If quality and patient satisfaction criteria are met and providers working together in an accountable care organization (“ACO”) or similar entity create savings for a defined patient population, then the ACO usually gets a portion of the savings, commonly 50 percent. Unlike capitated arrangements, shared savings arrangements can avoid or limit downside financial risk and therefore can serve as stepping stones toward fuller accountability and incentivization. They are quite appropriate for startup and smaller ACOs. This paper does not address recommendations for determination of the savings amount nor sharing between the ACO and payer. Because of its immediacy, we primarily will focus on intra-ACO distribution of savings under the Medicare Shared Savings Program (“MSSP”).

It is well documented that our current largely fee-for-service system is unsustainable and that a dramatic incentive shift must occur.

The ACO gets the savings, if there are any, but what it does with them is crucial to the success and sustainability of the organization. “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.”¹



If any provider or hospital stakeholder feels that THEIR efforts to drive value are not being fairly recognized, they will no longer participate meaningfully, the goals of value-based medicine will be thwarted and savings will not occur in the long-run. For these reasons, as noted in the accompanying Physician’s Accountable Care Toolkit©, before signing a participation contract,

physicians should scrutinize how each ACO plans to distribute the savings it receives.

The Centers for Medicare and Medicaid Services (“CMS”) administers the MSSP. The CMS’ MSSP regulations are not prescriptive about a given savings distribution formula, allowing ACOs flexibility, but they are specific about the ultimate purpose of distributions: “As part of its application, an ACO must describe the following: (1) how it plans to use shared savings payments, including the criteria it plans

¹The Dartmouth Institute, *The ACO Toolkit*, p. 9 (Jan. 2011)

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to employ for distributing shared savings among its ACO participants and ACO providers/suppliers, ... and (3) how the proposed plan will achieve the general aims of better care for individuals, better health for populations, and lower growth in expenditures .”²

Some ACOs, however, have lost sight of the fact that failure to have a fair shared savings distribution formula (linking relative distributions to relative contributions) will be fatal to their sustainability. Some view them as “profits” to go to the owners or shareholders. Some simply lock in a fixed allocation similar to fee-for-service payment ratios, without regard to who generated the savings. Some employers of physicians have contracted to compensate only on a work production basis with zero performance incentive payments at all. Other ACOs are putting off the issue because it is sensitive culturally. As health care moves more and more to value-based compensation, the distribution of savings must be viewed primarily as the providers’ professional remuneration and not corporate “profit.” Payments for administrative services and debt service must, of course, come out of the savings distribution to “keep the pump primed,” but should be carefully managed. The bulk must be distributed in proportion to contribution toward quality and cost-effective care.

At the same time, the distribution model needs to be clear, practical, and capable of being understood by all.

One physician stated, “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.” To those putting off design of a fair merit-based compensation system until there is more physician buy-in, we respectfully submit that you cannot get buy-in without one.

Yes, this concept is pretty basic when you think about it. But though it may be easy to understand, it can be complex to implement, especially when multiple specialists and facilities are involved in an ACO’s care coordination. One not only needs to determine the relative potential and actual value contribution for each provider, but also the clinically valid metrics by which to measure them. Under fee for service, metrics for success were usually transactional and objective (i.e., volume of procedure x rate). An ACO’s success metrics may be neither. Success may come from things not happening (i.e., fewer ED visits, avoidable admissions and reduced readmissions). At the same time, the distribution model needs to be clear, practical, and capable of being understood by all.

The purpose of this guide is to provide a replicable framework for any ACO to use to create a fair and sustainable shared savings distribution model. There are necessary subjective judgments—at this time, many metrics are imprecise or nonexistent—and the sophistication of the distribution process must parallel the sophistication of the ACO’s infrastructure. But, if the right people are involved and apply the ACO’s guiding principles on savings allocation, participants will be appropriately incentivized.

²42 CFR 425.204(d), 76 Fed. Reg. 6798 (Nov. 2, 2011).

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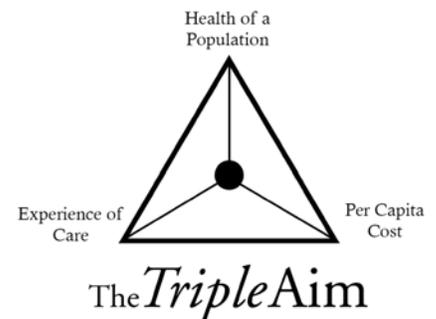
The precision of distribution application will grow over time. Don't let the perfect be the enemy of the good.

B. THE SIX GUIDING PRINCIPLES FOR SHARED SAVINGS DISTRIBUTION

Though application will vary widely due to differing circumstances and types of initiatives, chances for success will increase if every activity can be judged by whether it is consistent with a set of guiding principles viewed as fair by the ACO members .

The savings distribution formula should have the following principles:

1. **Furtheres Triple Aim** – It incentivizes the delivery of high-quality and cost-effective care to achieve the Triple Aim—better care for individuals, better health for populations, and lower per capita costs;
2. **Broad Provider Input** – It is the result of input from a diverse spectrum of knowledgeable providers who understand what drives patient population value;
3. **Fair** – It is fair to all in that it links relative distribution to relative contribution to the organization's total savings and quality performance, and adheres to measurable clinically valid metrics;
4. **Transparent** – It is clear, transparent, practical to implement and replicable;
5. **Constantly Evolving** – It adapts and improves as the capabilities and experience as of the ACO grows;
6. **Maximizes Incentive to Drive Value By All Participants** – After prudently meeting overhead costs, allowing some gradualism for transition, and allowing commercially reasonable return on capital investment or debt service, it maximizes ongoing incentivization for all to deliver value by distributing as much of the savings surplus as possible to those who generate.



Guiding Principles

1. Furtheres Triple Aim
2. Broad Provider Input
3. Fair
4. Transparent
5. Constantly Evolving
6. Maximizes Incentive to Drive Value By All Participants

C. WEIGHTING—HOW TO ASSIGN RELATIVE PERCENTAGE AMONG PROVIDERS

As mentioned, it is important that design of a fair distribution formula be the product of collaboration among informed and committed clinicians who understand patient population management. Like virtually all organization compensation formulas, the determination of relative contributions of the different providers in a given ACO, or care initiative within the ACO, will involve a certain amount of inherent subjectivity, but ideally will be guided by weighted criteria applied in good faith.

1. Step One—Break Down Each Initiative Into Its Value-Adding Elements and Assign Provider Responsibility for Each

The ACO will have a number of different care management initiatives. Some, like outpatient diabetes management, may be completely the responsibility of one provider specialty, (i.e., primary care). Others may involve coordination across multiple settings for patients with multiple conditions involving multiple specialties. Each initiative was chosen for a reason—to drive value. In setting relative potential distribution percentages, envision the perfect implementation of each initiative. Next, look at what tasks or best practices are needed to drive success, and then who is assigned responsibility for each.

Strategic Note: If you break down your initiative into its value-adding elements in this way, you may be surprised to find that non-direct-care activities, such as care coordination, knowledge management, and transition management across our fragmented and siloed system, are among the most powerful drivers, including for specialties.

Strategic Note: The Geisinger Clinic recommends for all ACO initiatives that the ACO reverse engineer its initiatives into separate steps, next assign clinical responsibility for each step, and then embed data support for every step where feasible.

There will be individual tasks, such as adherence to disease state management best practices, and some team tasks, such as referral management and coordination among the care team.

2. Step Two—Assign Relative Percentages to Each Specialty Relative to Their Potential to Realize Savings

For a pure primary care prevention initiative, they would get 100 percent in all categories. For multispecialty initiatives, the percentage is tied to the proportion of those savings predicted to flow from that provider class. A hospital actively engaged in coordinating and streamlining care is obviously

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a “provider” for purposes of these savings pool distribution calculations, but the key for all must be savings distribution relative to savings contribution.

Caution: Historically, Cost Centers Are Not Necessarily the Cost Savers – A mature ACO will be able to allocate savings to each initiative and the relative savings distribution within each. But for a start-up ACO, because it is so apparently logical and fits the traditional fee-for-service mindset, it is tempting to look at claims differences in the various service categories, such as inpatient, outpatient, primary care, specialists, drugs, and ancillaries, and attribute savings to the provider historically billing for same (i.e., hospitals get “credit” for reduced hospital costs). However, a successful medical home wellness, prevention, or lifestyle counseling program may be the reason those patients never go to the hospital. The radiologist embedded in the medical home diagnostic team may have helped make an informed image analysis confirming a negative result and avoided those admissions. But, do use those service categories to set cost targets.

These percentages are based on potential savings contributions. Whether a provider actually attains that full potential distribution amount depends on his or her performance score as set forth in Step Three.

3. Step Three – Individual Attribution

We now know every provider group’s potential savings, but how do we determine the actual distribution based on actual results? As discussed in the next section, metrics (measures) must be selected that are accurately associated with the desired individual and collective conduct of that provider class. They should cover both quality and efficiency. In the value-based reimbursement world, even if the performance is superb, if it is not measured appropriately, it will not be rewarded.

Strategic Note: Section 3003 of the Affordable Care Act mandates that CMS develop an episode grouper. That work is still underway to complete this complex but important tool. It is anticipated that the episode grouper software will allow for the bundling of payments to facilitate attribution to providers in clinical episodes and could potentially facilitate cost profiling of both individual and group providers to drive quality improvement. Our shared savings distribution model, by measuring and fairly rewarding individual physician input to an initiative, will serve as a non-clinical counterpart to the episode grouper. Readers should monitor the development of the episode grouper software to see if it meets the potential to facilitate your efforts.

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Once the proper metrics are selected, each provider's performance is measured.

Which Yardstick? – The score could be based on a ranking of providers or in comparison to a benchmark. An ACO may look at its own benchmark data, external norms, or a combination. The quality and efficiency scores are grouped and weighted to create the total score.

Multiply Score by Patient Volume – Often, once the composite score is determined, it is multiplied by the physician's patient volume. This is most easily understood in regard to primary care physicians in a patient-centered medical home.

Strategic Note: Unleash ACO Savings by Incentivizing the Full Spectrum of Specialist Contributions – Some allocation “buckets” for specialists have been limited to that specialist's severity-adjusted volume of services or their RVUs. However, emerging ACO value-add strategies for virtually all specialties involve such things as care coordination, knowledge, management, and transition coaching with the patient and the care team (i.e., neurologists with the medical home's stroke clinic or radiologists aiding the initial patient diagnosis process). Recognizing a specialist only for reducing episodes within their respective silos of care marginalizes them as mere commodities. As the National Center for Quality Assurance (“NCQA”) states regarding its standard development for its Patient-Centered Specialty Practice Program, “There is a solid research base to support the need for better coordination between PCPs and specialists/subspecialists...” NCQA further found that the financial benefit therefrom could equal or exceed those realized through all the clinical interventions for the patients.³ Break down the way in which each initiative can drive value, assign clinical responsibility for each, and incentivize that responsible provider by matching the savings attribution to that designated contribution activity. For example, the NCQA Patient-Centered Specialty Practice Draft Standards measure such activities as referral criteria among specialists, co-management transition strategies, timely response to primary care providers, non-visit consultations, patient communication, proactive patient reminders in coordination with primary care, self-care support, medication management, information sharing with hospitals and emergency departments, and transition of care effectiveness. Specialists in accountable care arrangements are not procedure factories, and their shared savings score cannot be limited in such a manner.

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³ <http://www.ncqa.org/Programs/PatientCenteredSpecialistPracticeRecognition/SpecialtyPracticeProgramDevelopmentBackground.aspx>.

D. SELECTING THE RIGHT MEASURES

In one study, the Commonwealth Fund noted: “Almost every observed shared-savings model uses performance metrics on access, patient experience, quality and/or service utilization to determine the percentage of savings the provider will receive.”⁴ It found that, “Overall, preventive care, chronic illness care (process measures and interim outcomes measures), and utilization (efficiency) measures were all employed with approximately equal frequency in the studied models, while access and patient experience each appeared to be used about a third less often.”⁵ While appropriate metrics are crucial, current quality, efficiency and utilization measures are works in progress and should be constantly improving and evolving overtime.

Interestingly, the MSSP has no utilization/efficiency measures. Startup and early-stage ACOs will necessarily be limited more to ambulatory process measures because its data is limited to claims data. As ACOs mature to collection of specific clinical data and limited survey data, they will shift toward outcomes metrics associated with the disease state’s process measures. Full EHR interoperability, data registries, and robust patient-generated data will allow best-case granular process, outcomes, and utilization measurement.

Generally speaking, for quality measures, there are numerous clinically credible sources. The most immediate are the 33 quality measures found in the CMS MSSP. Others include standards endorsed by the National Quality Forum (“NQF”) and the CMS’ physician quality reporting system (“PQRS”), and measures developed by the American Medical Association Physician Consortium for Performance Improvement (“AMA PCPI”) and the National Committee on Quality Assurance (“NCQA”) (i.e., the Healthcare Effectiveness Data and Information Set (“HEDIS”), the Patient-Centered Medical Home Standards, and the Patient-Centered Specialty Practice Standards). The efficiency, or savings, measures are different. As noted, it is important to look at the initiatives chosen to close gaps in care, the actual individual and team activities desired to achieve those goals and to select the most appropriate measures that reflect this activity. Since many of the desired outcomes will be things that do not happen, and the activities, especially of specialists, will reflect novel re-engineering of their skill sets, comparatively speaking, expect the efficiency metric selection exercise to lack objective precision.

How physicians measure up against their peers has been found to be a more powerful incentive than financial reward.

⁴The Commonwealth Fund, *Key Design Elements of Shared-Savings Payment Arrangements*, p. 9 (Aug. 2011).

⁵ *Supra*.

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1. Quality Metrics

These should track peer reviewed and accepted evidence-based best practices relevant to each initiative. They should involve nationally-recognized process and outcomes measures, such as screenings and vaccines. Different disease states initiatives will involve different specialists and require different measures. A powerful quality/efficiency tool must be transparent among like specialists in their relative scores on adherence to the selected evidence-based best practice, severity adjusted. How physicians measure up against their peers has been found to be a more powerful incentive than financial reward.

2. Efficiency Metrics

Costs are determined by the patient population's actual health status, individualized care decisions, and team systems of care. The process measures should track adherence to the assigned individual and team conduct. There are many possible outcomes measures—low acuity ED admits, hospital days/1,000, length of stay, generic dispensing, reduced hospitalizations, C-section rates, lower-cost settings, and lower ED use.

E. KEEP IT SIMPLE AND OPEN

Pick a few of the most widely recognized quality and efficiency metrics and have them and the data collection process thoroughly vetted by the providers. Following the guiding principles, the distribution model will be a success if: (1) everyone understands that this is the best practical approach, (2) the process has been open, and (3) everyone is acting in good faith to have as fair a shared savings distribution process as the current sophistication level of the ACO's infrastructure allows. It cannot be viewed as coming from a "black box." For a young ACO, it will at best be crude in the beginning.

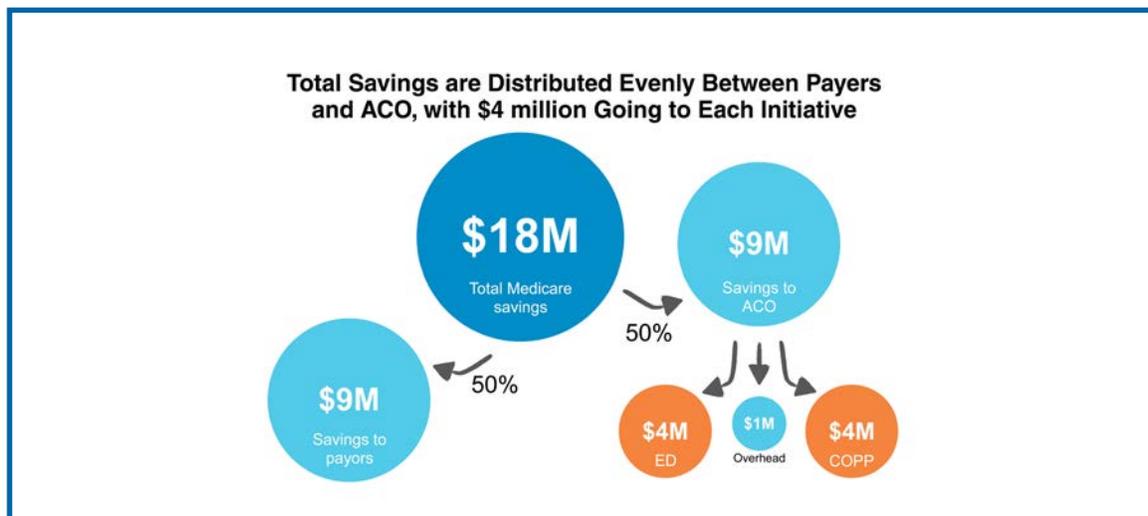
F. APPLYING THE PRINCIPLES

"We Care ACO" is a hypothetical physician-sponsored ACO with a primary care patient-centered medical home core and select specialists, handpicked for their value-added capabilities to maximize the success of the ACO's initiatives. The initiatives were picked once the ACO did a gap analysis of local high costs attributable to unjustified variations in care. The top two were emergency department overutilization for non-acute care and the coordination of care for obese patients with at least one co-morbidity. We Care ACO actually was quite successful in generating overall savings of 18 million

⁶ This example is a rough compilation of several actual ongoing, more mature, ACO initiatives, simplified for illustration purposes. Amounts and percentages reported in the example are presented for illustration only and cannot be relied upon as indicative of expected results. It should be noted that for start-up ACOs in the first year, overhead is likely to be greater, and savings and results are not likely to be as significant, as this example portrays.

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for the 25,000 Medicare beneficiary patient population it was serving, evenly generated by these two initiatives. But the providers worked hard, saw fewer patients, and a number of physicians declared “this better be worth it” and, privately, “my contributions better be appreciated.” The president worried, “How in the world will we divide the savings pool ‘pie’?” Fortunately, the physician chairs of the ACO’s Finance and Clinical committees were members of the Toward Accountable Care Consortium (TACC) and had been preparing for success using this merit-based shared-savings distribution framework.



1. Summary of the Initiatives of the ACO

With a merit-based allocation model, where distribution is proportional to contribution, one must first understand who is doing what to create the savings. After looking at the greatest avoidable gaps in care for its assigned patient population and the capabilities to close those gaps of the ACO members, We Care ACO decided that the proverbial “low-hanging fruit” consisted of the following:

a. The ED Overuse Initiative

The primary care physicians proactively contacted all new patients to inform them of extended hours of availability for medical needs. They gave out refrigerator magnets with a nurse triage hotline to use in lieu of patients defaulting to the local emergency room for after-hours treatment. They shared call and coverage for 24/7 access and placed a triage nurse in the hospital emergency department to divert non-emergent patients while following patient care best practices and meeting EMTALA requirements. Despite requests, neither the hospital nor the emergency physicians chose to participate in this initiative. Referrals by practices to the emergency department for non-emergent cases were tracked. Applicable quality metrics for the diagnosis and treatment of the

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relevant disease states were monitored. The ACO targeted this initiative since this had been a chronic problem in the fee-for-service environment and saw potential opportunity for improved quality and more appropriate use of scarce medical resources and savings. They were right. Emergency department visits dropped 14 percent, resulting in total savings of \$8.5 million. Had the hospital and emergency physicians participated, their predictive model showed that the savings would have been increased to \$10.5 million.

b. The Complex Obese Patient Project (“COPP”) Initiative

The COPP focused on the “super utilizer” complex obese patient population. The goals of the project included weight reduction, co-morbidity identification and management. The physicians involved sensed that significant improvements in care, as well as cost savings, could be created through more efficient care delivery. In its inaugural year, the COPP saved \$8.5 million while improving care and quality of life.

A multi-disciplinary physician team outlined current best practices across the care continuum and implemented those best practices while focusing on provider-to-provider communication. We Care ACO instituted: (1) better information and clinical support at the primary care diagnosis



and treatment phase, (2) better information flow along the entire continuum of care, (3) improved transition from the outpatient to the inpatient setting, (4) improved perioperative processes and outcomes, and (5) improved post-op follow up. Significant savings were derived from prevention, chronic disease management, care transitioning, and process improvement.

A complex obese patient comprehensive data template was created and used to facilitate patient intake in the system and later hand-offs between members of the clinical team. The database derived from this template, as well as that from the ACO’s informatics center, helped to identify high-risk patients within their patient population.

The physicians recognized the need for additional clinical expertise and recruited a nutritionist, mental health professional, pharmacist and case navigator to round out their newly created Complex

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Obese Patient Support (“COPS”) team. To their surprise, many of these services already existed in their community but had never worked in a coordinated manner with the physicians. The COPS team provided real or virtual access to specialized expertise for optimal co-morbidity diagnosis, weight management and treatment planning. Tools for patient education and engagement, as well as relevant clinical decision support and data, followed the patient and were accessible to all providers via a web-based, virtual workstation.

Morbidly obese patients are often difficult surgical candidates with many medications, co-morbidities and other high-risk issues. They often require surgeries due to their poor health status. The assembled multi-specialist team recognized this issue and, led by an anesthesiologist, created an anesthesia specific pre-operative assessment algorithm to identify, and reduce, perioperative risk.

This step completed the “Obesity Medical Home” model. The anesthesiologists became transition coaches for patients entering the hospital for surgery and the template-derived clinical data assisted the hospital team for nonsurgical admissions. Any surgeries followed optimum perioperative process best practices and utilized the virtual workstation. Post-op and post-discharge, the patient was transitioned back to their Medical Home.

Weight loss surgery was recommended ONLY if the patient was unsuccessful losing weight by nonsurgical means after a +/- six-month time period. If a patient otherwise was a proper candidate (i.e., BMI, health status, etc.) and the surgery comported with evidence-based best practices, then the patient met with a bariatric surgeon to discuss their surgical options. After the surgery, a post-weight-loss-surgery patient follow-up protocol was managed by the Medical Home physician with ongoing support from the COPS team.

As opposed to the ED Management initiative, the COPP initiative had many more “moving parts,” with more providers, care transitions, etc. However, care coordination across settings for chronically ill patients is one of the richest target fields in accountable care, and We Care ACO knew it had to figure out a savings distribution methodology that was as fair as possible to all contributors.

After breaking down the initiatives into their separate tasks, clinical responsibility was assigned to each provider pool as follows:

1) Primary Care Physician

The primary care physicians led the patient-centered medical homes and were responsible for implementing patient education and engagement tools, reaching out to specialists for relevant information first via algorithms and educational materials through the physician workstation,

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telephone, and e-mail, then using the referral protocols. They engaged in motivational interviewing. Patients were worked up for their frequent operations per the predetermined process. They were informed of status when admitted, followed the patient as appropriate, and were ready for the handoff upon discharge per protocol. The primary care physician's care coordinator saw the patient in their home within five days of discharge, and the patient was supported per the ACO protocols. They had additional coordination responsibilities and were more proactive in engagement and lifestyle management across the full patient population.

2) Anesthesiologist

The anesthesiologists in We Care ACO served as the COPP support team “coaches,” pulling together all the disparate specialists to support the medical home primary care physician's diagnosis, planning, treatment and care coordination of these exceedingly complex patients. The anesthesiologist supplied the evidence-based anesthesia pre-op testing protocol, a standardized protocol for pre-surgical testing and co-morbidity identification and management. Patients are screened using this protocol with individualized patient testing directed on an as needed basis.

The protocols were compared to patient information previously compiled in the virtual workstation to identify gaps in care. The anesthesiologist guided the care coordinator in finding pre-existing clinical data in the patient's record to avoid duplicative testing. It included a telephone screening process. The “dossier” of data followed the patient through the perioperative process and was available at the point of care across the care continuum.

Once the COPP patient was admitted, the anesthesiologists assumed responsibility for the patient's perioperative process and co-management with the surgeon to optimize high-quality, cost-effective care. They provided leadership and sponsored performance improvement efforts. Morbidly obese patients, because they can be medically and technically difficult to manage, often make routine surgical procedures complex, another reason why this high-risk, high-cost patient population is appropriate for focus. The anesthesiologists led development of standard protocols for preoperative medication regimens and were active in efforts to improve pre-surgical patient flow for these patients, an acknowledgment that complex obese patients were disproportionately responsible for delays, cancellations, and complications.

Strategic Note: An anesthesiologist was not the only one who could handle the COPP tasks of organizing support by specialists, transition management in and out of the hospital, or the development of certain protocols, but We Care ACO had a particularly motivated anesthesiologist “champion” to fill the roles. Will this extra effort pay off in a merit-based ACO shared savings distribution plan?

3) Cardiologist

The complex obese patient often has heart and circulation related issues requiring the expertise of the cardiologist. The challenge, however, with the ACO's initiative was how to access and coordinate that expertise in a timely manner. The cardiologists and primary care physicians enjoyed helping each other in knowing when and how to coordinate. Standing referral management protocols helped, as well as e-mail and telephone communications. The cardiologists were key members of the COPP specialist support team for the medical homes. Patient communication and feedback to the attending physician also improved.

4) Nephrologist

Morbidly obese patients have a higher than average incidence of renal failure. The nephrologists assisted the medical home with creating hypertension goals and management plans.

5) Pulmonologist

Morbidly obese patients have a high incidence of obstructive sleep apnea (OSA). The pulmonologists (and anesthesiologists) created an effective OSA screening protocol to determine which patients required a formal sleep study. Those determined to have OSA were placed on appropriate therapy.

6) Endocrinologist

Morbidly obese patients have a higher than average incidence of type 2 diabetes (DM2). The endocrinologists helped the medical home by creating treatment algorithms for DM2 as well as referral guidelines from the medical home to their clinic.

7) Surgeon

Morbidly obese patients may benefit from bariatric surgery if they cannot manage their weight via nonsurgical means. All patients were given information about their surgical weight loss options during their initial visit and those patients who did not lose weight by the end of six months were given the choice of meeting again with a surgeon to discuss their options.

Patients having surgery had been medically optimized during the prior six months, resulting in lower anesthesia and surgical risk.

After the procedure, the surgeon coordinated with the medical home physician discharge plans and follow up. The patient was then returned to their medical home for ongoing management.

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2. Designing the ACO Shared Savings Distribution Plan

Applying the Six Guiding Principles for Shared Savings Distribution and systematic procedures outlined above, We Care ACO providers reached consensus on a beginning fair apportionment model that they hoped would sustain the incentive of all to continue to contribute to high-quality care with maximum savings year after year. There also was consensus that the process would remain transparent and would gain definition and accuracy as the ACO's sophistication grew and nationally recognized metrics developed further.

It was agreed that because the teams and tasks involved were so different, the savings attributable to each initiative would be tracked separately. Each would make distribution calculations to the individual provider level. The sums would then be added for physicians participating in both and distribution checks sent to each provider.

[Editor's Note: For readability and brevity, duplicative portions of the analysis are excluded.]

a. The ED Overuse Initiative

Step One: Breakdown Into Elements and Assign Clinical Responsibility – This is relatively easy in that the primary care physicians are 100 percent responsible for all the tasks in this initiative, since the ACO has not yet involved the emergency physicians and hospital.

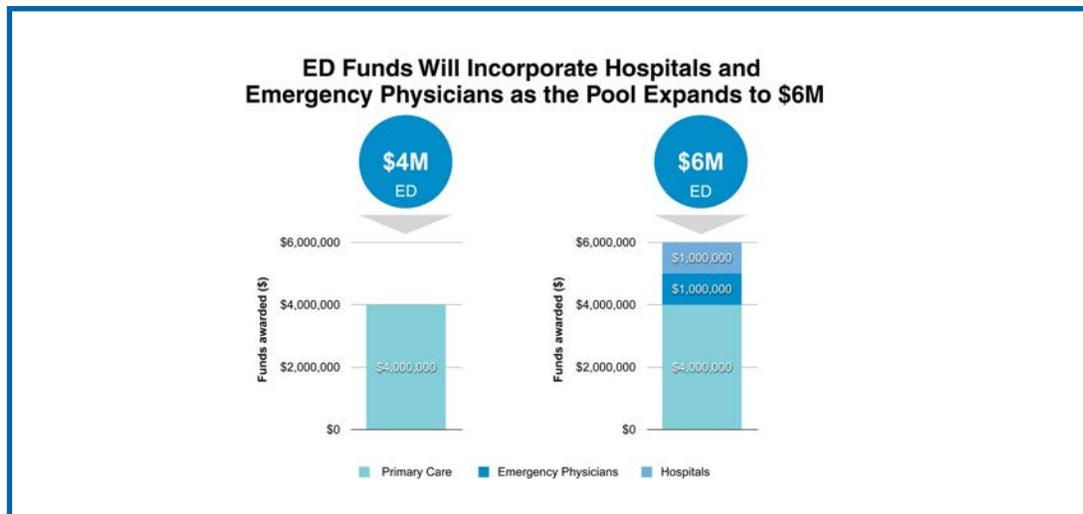
Step Two: Assign Percentages – Since there is only one provider group (primary care physicians), there is no need to apportion.

Step Three: Individual Attribution – The performance of the primary care physicians participating in the initiative was evaluated based upon a “starter set” of nationally-recognized quality, efficiency, and patient experience criteria, using the MSSP criteria wherever applicable. To receive any savings a “gate” of meeting minimal performance metrics was required. Each primary care physician was then ranked comparatively within the ACO on the criteria. Actual savings per physician were relatively easy to track, as the physicians knew exactly who within the patient population had been assigned, or “attributed,” to them.

Step Four: The ED Overuse Initiative Results – The participating practices took pride in the initiative and felt that the process, albeit crude and imprecise due to limited data, was fair. They agreed to meet with the Financial and Clinical Committees of We Care ACO to refine the ED Overuse Initiative, its metrics, and data capture. Importantly, they were even more enthusiastic to engage in the initiative next year. Seeing the upside potential, the ACO will earnestly recruit the emergency physicians and hospital to join in the initiative, with shared savings to each according

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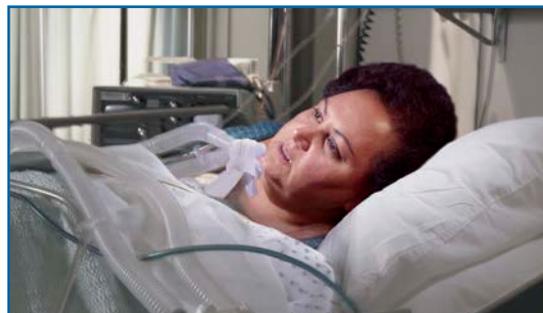
to the model, while maintaining, or even increasing, their distributions, in light of the predicted larger shared-savings “pie” due to synergies. Seeing the powerful incentivization from this merit-based distribution model, each practice took ownership to incentivize its non-physician, value-adding providers in a meaningful way, as well.



b. The Complex Obese Patient Project

Step One: Break Down Into Elements and Assign Clinical Responsibility – We Care ACO knew that this was one of the greatest potential areas of care improvement and waste avoidance for its patient population. As the program summary reflects, it sorted through the tasks involved, who would compose the COPP team, and their relative responsibilities.

Step Two: Assign Percentages – The multidisciplinary COPP team met several times with the Clinical and Financial Committees. It reviewed available literature on the obesity epidemic, its costs, areas of potential savings, and savings predictions associated with various interventions. Each physician added experiential knowledge on the potential savings



from remediation of each breakdown of care coordination and transition. They did not have access to predictive modeling services, which would have been useful. The committee allocated savings potential by pool by assigning a subjective, good-faith prediction of savings to each category.

A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

Strategic Note: It is important to remember that this is not a win/lose analysis, but a win/win, in that another provider's success and increased compensation does not mean that you get less, but tends to be synergistic to everyone's success. Everyone wants everyone else to meet their full potential.

The assigned percentages based on potential contribution under COPP were agreed to be:

- Individual Process Measures and ACO Efficiency – 25 percent.
- Teamwork Measures – 35 percent.
- Outcomes Measures – 25 percent.
- Transition Management – 15 percent.

Step Three: Individual Attribution – Each specialist now knew what to do and their value-add potential of doing it. However, the fairness of the individual scoring system is only as good as the performance metrics assigned to each provider's responsibilities. The ACO's clinical committee knew that the entire validity of the savings distribution model depended on each affected specialty believing that their "scorecard" represented a clinically valid measurement of their delivery of quality and efficiency. Each specialty group was consulted and had committee representation. Nationally recognized metrics were used, when available, with the CMS MSSP quality metrics being the leading standard. Because this is primarily a multispecialty coordination and transition initiative, the NCQA Medical Home and Specialty Practice referral management coordination and transition standards proved most useful. At the end of the day, it confirmed that the clinicians may start with the available metric "menus," but must tailor the scoring to its circumstances and initiatives. Given the complexity of the COPP initiative and the early-stage data capture limits of the ACO, the committee knew that it could only achieve a limited level of precision. It did not want a wave of metrics to overwhelm the providers.

This process resulted in the following COPP Initiative Scoring Guidelines:

1. Individual Process Measures and ACO Efficiency

This pool constituted 25 percent of the total COPP savings pool. Primary care and specialist physicians were all determined to be accountable for both individual process measures and ACO efficiency metrics, although the individual process metrics for each specialty varied. Individual scorecards for each physician specialty reflected the individual process measures

A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

deemed most appropriate for the specialty. In the use of physician scorecards, measures varied by specialty, but the aggregate score for all measures for each COPP Performance Category was a maximum of 100 points for full attainment of all applicable metrics to allow for equal measurement across diverse specialties. For purposes of individual efficiencies, the cost of care for cases below target for each provider was computed as a percentage of the aggregate for all providers to determine a percentage for individual savings. For ACO efficiency, individual scores from the physician scorecards were weighed against aggregate scores for all providers to determine a second percentage. The net percentages were weighted 70 percent and 30 percent for individual savings and ACO efficiency, respectively, to arrive at a weighted average rate to be applied to the total COPP savings pool.

2. Teamwork Measures

This pool constituted 35 percent of the total COPP savings pool. The participation by surgeon, anesthesiologist, and subspecialist physicians depended upon patient subgroups. PCPs were part of all four subgroups. Subgroups and participating specialties were assigned by committee, as follows:

- **Subgroup A** – Patients with only PCP interaction. This subgroup is comprised of PCPs and anesthesiologists as managers of patient care.
- **Subgroup B** – Non-surgical patients with internal medicine subspecialist intervention. This subgroup encompasses Subgroup A physicians and the addition of cardiologists, endocrinologists, nephrologists, and pulmonologists.
- **Subgroup C** – Surgical patients without internal medicine subspecialist intervention. This subgroup is made up of Subgroup A physicians and discharge physicians.
- **Subgroup D** – Surgical patients with internal medicine subspecialist intervention. This subgroup is all-encompassing.

Initially, each subgroup was assumed to have equal volume of patient encounters; however, as data is accumulated on patient volumes, encounter volume by subgroup will result in modification of the weight assigned to each. Within each subgroup, it was determined that participating non-PCP physician specialties would receive 10 percent of the allocation of the pool, with the anesthesiologists receiving an additional 10 percent in the surgical subgroup. PCPs receive the balance of the pools' funding. From each specialty's funding, each physician received scoring based on teamwork metrics, with some differing by specialty. The following are examples of teamwork metrics:

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- Getting Timely Care, Appointments and Information
- How Well Your Doctors Communicate
- Shared Decision Making

Individual provider scores for teamwork relative to aggregate scores for all providers in the subgroup for teamwork were computed to arrive at a percentage share of the pool associated with each provider subgroup, which were then further weighted by patient volume within each subgroup to determine a weighted average share of the teamwork measures pool for each participating physician.

3. Outcomes Measures

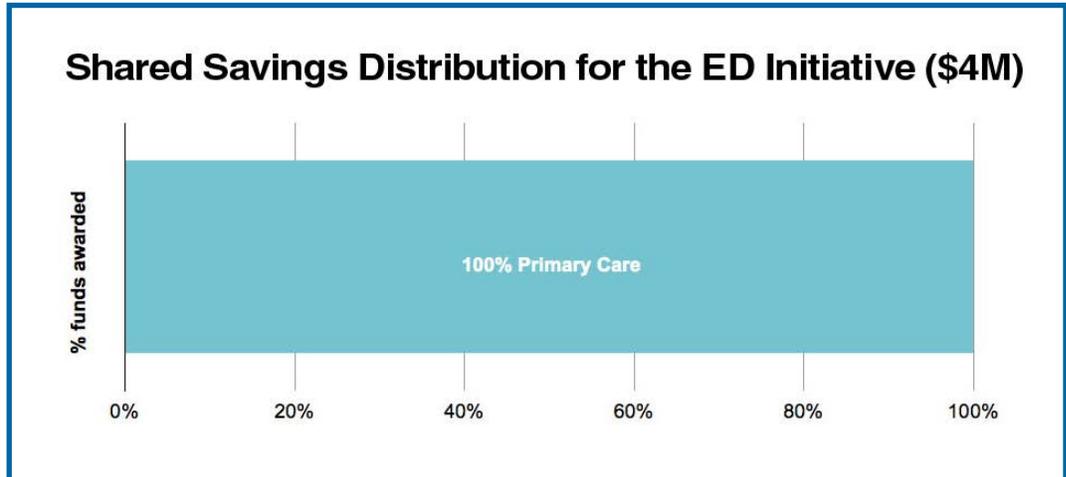
This pool constituted 25 percent of the COPP distribution. Outcomes measures were determined to apply to all providers, regardless of specialty. Based purely on successful attainment of outcomes measures using the physician scorecard, each physician's score was compared to the aggregate score of all physicians in the ACO to determine the individual physician's share of the ACO outcomes measurement pool.

4. Transition Management

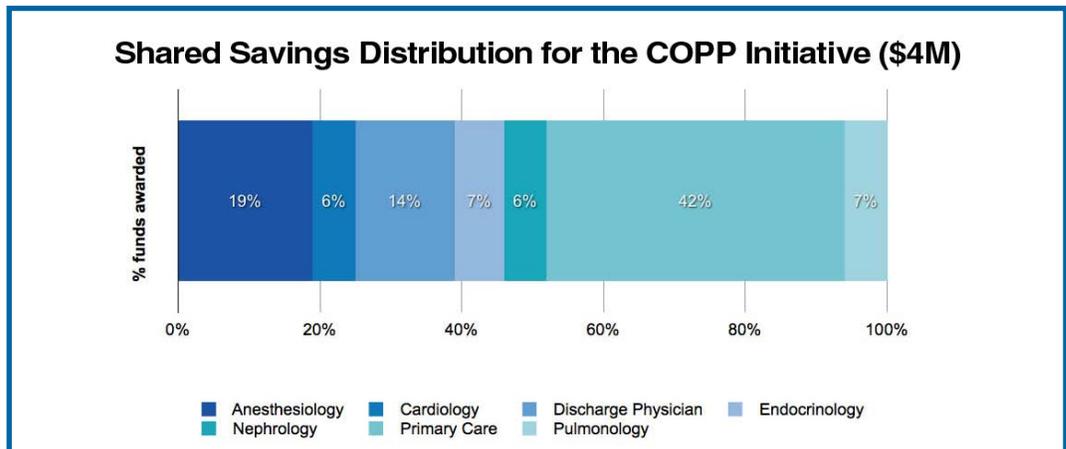
The remaining 15 percent of COPP funds were ascribed to the transition management role. Because closely coordinated transition management is key to the success of high-cost complex patient coordination projects such as the COPP, a separate transition management distribution pool was determined to be the best way to match distribution with value contribution for this initiative. Applicable only to physicians providing primary care (primary care physicians), discharge (surgeons), and perioperative management services (anesthesiologists), the transition management pool was to be distributed based on the episodes of care by physicians in these specialties relative to the aggregate episodes of care by all physicians within the three applicable specialties, the proportion of which would be multiplied by the individual physician's scorecard score for transition management measures. This formula determined each individual physician's share of the transition management pool of funds for the COPP initiative.

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5. Application of the COPP Initiative Individual Scoring Guidelines

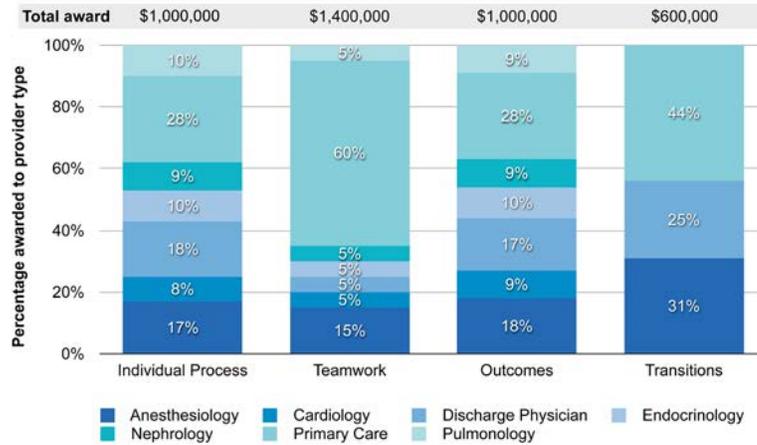


Step Four: The Complex Obese Patient Project Results – Despite lack of first-year exactitude in measurement, the ACO members felt that their efforts were recognized and are motivated for next year. They became painfully aware how far ahead this type of multispecialty initiative is in precise quality, efficiency, individualized attribution, or other data capture; much less benchmarks or standards. Their comfort came from knowing that all this was done in good faith, using the crude tools available and honoring the ACO distribution guiding principles. One telling take-away was that all members realized the financial benefit from the non-direct-care tasks of coordination, patient engagement and transition management, and several committed to be more active in these value-adding activities. Each practice receiving distribution payments committed to distribute some of the payments among value-adding non-physician providers on the “team.”

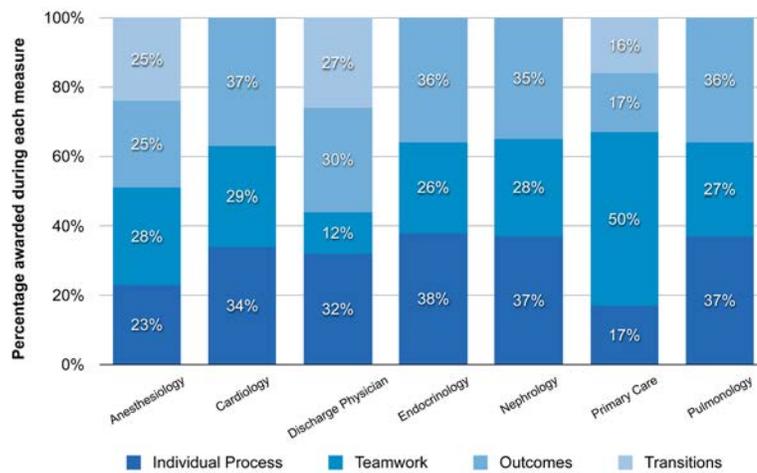


A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

Distributions for the COPP Were Similar for Individual Process and Outcomes Measures



Distributions by Measure are Similar Across Provider Type, with Primary Care Over-Indexing on Teamwork



G. CONCLUSION

Even at this dawning of the movement to value-based reimbursement in health care, a framework for a fair merit-based shared savings distribution is available to all ACOs. As ACOs gain actual performance data, their health information technology capabilities improve, and refined quality and efficiency metrics emerge, the process

Even at this dawning of the movement to value-based reimbursement in health care, a framework for a fair merit-based shared savings distribution is available to all ACOs.

will evolve from an open and good-faith application of the guiding principles with limited tools, to more and more refined determinations of the sources of the ACO's quality and savings results. The path will get easier over time, but the destination is always clear—distribution in proportion to contribution.

[NOTE: THE "WE CARE" CALCULATIONS WERE COMPILED BY HORNE AND CAN ONLY BE EDITED BY HORNE.]

Developing an ACO Shared Savings Distribution Plan

Step one: **Breakdown Into Elements and Assign Clinical Responsibility**

Step Two: **Assign Percentages** (in a complex project like the COPP, subgroups for each patient type of interaction and the associated subspecialty physicians will need to be assigned.)

Step Three: **Individual Attribution**

- a. Individual Process Measures and ACO Efficiency
- b. Teamwork Measures
- c. Outcomes Measures
- d. Transition Management
- e. Application of the Initiative Individual Scoring Guidelines

Step Four: **Results**

A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

WE CARE ACO - HYPOTHETICAL

Hypothetical Schedule of Shared Savings Revenue and Expenses (1)

	<u>Amount</u>
Total savings generated for the Medicare program	\$ 18,000,000
Shared savings rate in accordance with the Medicare Shared Savings Program ("MSSP")	<u>50.0%</u>
Net MSSP shared savings revenue earned by ACO	9,000,000
Total overhead, physician administrative compensation, infrastructure reinvestment, debt service, return on investment, and other expenditures	<u>(1,000,000)</u>
Net ACO shared savings available for distribution to providers	<u>\$ 8,000,000</u>

Note:

(1) Hypothetical example only. Amounts and percentages reported in the example are presented for illustration only and cannot be relied upon as indicative of expected results.

A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

WE CARE ACO - HYPOTHETICAL

ED Overuse Initiative (1)

	Amount
Net ACO shared savings available for distribution to providers	\$ 8,000,000
Portion of shared savings distribution allocable to ED Overuse Initiative	<u>50.0%</u>
ED Overuse Initiative pool	<u>\$ 4,000,000</u>

Provider Class	Provider Specialty	Weight (2)	Amounts
Physician	Anesthesiology		\$ -
	Cardiology		-
	Discharge Physician		-
	Endocrinology		-
	Nephrology		-
	Primary Care	100.00%	4,000,000
	Pulmonology		-
		<u>100.00%</u>	<u>\$ 4,000,000</u>

Notes:

(1) Hypothetical example only. Amounts and percentages reported in the example are presented for illustration only and cannot be relied upon as indicative of expected results.

(2) To be apportioned among physicians in the specialty based on scorecard results for Individual Process Measures.

A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

WE CARE ACO - HYPOTHETICAL
Complex Obese Patient Project (COPP) (1)

Amount

Net ACO shared savings available for distribution to providers	\$ 8,000,000
Portion of shared savings distribution allocable to COPP	50.0%
COPP pool	\$ 4,000,000

Provider Class	Provider Specialty	Individual Process Measures				Teamwork Measures			
		Value of Individual Savings		Value of Individual Process		Value Assigned to Patient Subgroups			
		Weight (2)	Amounts	Weight (2)	Amounts	Subgroup A		Subgroup B	
						Weight (3)	Amounts	Weight (4)	Amounts
Allocation of Shared Savings Pool		17.50%	\$ 700,000	7.50%	\$ 300,000	8.75%	\$ 350,000	8.75%	\$ 350,000
Physician	Anesthesiology	16.82%	\$ 117,739	16.82%	\$ 50,460	10.00%	\$ 35,000	10.00%	\$ 35,000
	Cardiology	8.06%	56,400	8.06%	24,172			10.00%	35,000
	Discharge Physician	18.00%	125,997	18.00%	53,999				
	Endocrinology	10.15%	71,043	10.15%	30,447			10.00%	35,000
	Nephrology	9.18%	64,282	9.18%	27,549			10.00%	35,000
	Primary Care	28.01%	196,099	28.01%	84,043	90.00%	315,000	50.00%	175,000
	Pulmonology	9.78%	68,440	9.78%	29,331			10.00%	35,000
	Totals, All Providers	100.00%	\$ 700,000	100.00%	\$ 300,000	100.00%	\$ 350,000	100.00%	\$ 350,000

Notes:

- (1) Hypothetical example only. Amounts and percentages reported in the example are presented for illustration only and cannot be relied upon as indicative of expected results.
- (2) Individual process measures are represented by individual savings and contribution toward ACO savings. Of the 25 percent assigned to this pool, 17.5 percent (70 percent of the 25 percent) is allocated to this pool as a percentage of the aggregate for all providers, and individual scores from scorecards are weighted against aggregate scores to determine individual allocations.
- (3) Teamwork measures are allocated 35 percent of the COPP pool. Subgroup A represents non-surgical patients for whom no internal medicine subspecialists are required. From the COPP pool apportioned to teamwork measures and allocated to this subgroup based on patient encounters, 90 percent is shared among the PCPs and 10 percent among the anesthesiologists based on scorecard performance.
- (4) Subgroup B represents non-surgical patients for whom internal medicine subspecialists are required. From the COPP pool apportioned to teamwork measures and allocated to internal medicine subspecialties based on scorecard performance. Individual allocation is based on individual scorecard performance within the specialty.
- (5) Subgroup C represents surgical patients for whom no internal medicine subspecialists are required. From the COPP pool apportioned to teamwork measures and allocated to discharge physicians based on scorecard performance. Individual allocation is based on individual scorecard performance within the specialty.
- (6) Subgroup D represents surgical patients for whom internal medicine subspecialists are required. From the COPP pool apportioned to teamwork measures and allocated to internal medicine subspecialties based on scorecard performance. Individual allocation is based on individual scorecard performance within the specialty.
- (7) Outcomes measures represent 25 percent of the total distribution of the COPP distribution and are applied to all specialties regardless of specialty. Scoring is based on individual scorecard performance.
- (8) Transitions management measures represent 15 percent of the aggregate COPP distribution and are ascribed to the transition management roles by primary care physician scorecard performance relative to specialty performance.

A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

WE CARE ACO- HYPOTHETICAL (continued)
Complex Obese Patient Project (COPP) (1)

Teamwork Measures (continued)				Outcomes Measures		Transitions Management		
Based on Patient Volume								
Subgroup C		Subgroup D		Value of Outcomes		Value of Transition		Total Share
Weight (5)	Amounts	Weight (6)	Amounts	Weight (7)	Amounts	Weight (8)	Amounts	Weight
8.75%	\$ 350,000	8.75%	\$ 350,000	25.00%	\$ 1,000,000	15.00%	\$ 600,000	100.00%
20.00%	\$ 70,000	20.00%	\$ 70,000	18.26%	\$ 182,644	30.61%	\$ 183,653	
		10.00%	35,000	8.79%	87,913	0.00%	-	
10.00%	35,000	10.00%	35,000	16.82%	168,231	25.30%	151,784	
		10.00%	35,000	9.81%	98,135	0.00%	-	
		10.00%	35,000	8.55%	85,511	0.00%	-	
70.00%	245,000	30.00%	105,000	28.33%	283,264	44.09%	264,563	
		10.00%	35,000	9.43%	94,302	0.00%	-	
100.00%	\$ 350,000	100.00%	\$ 350,000	100.00%	\$ 1,000,000	100.00%	\$ 600,000	

of the pool) is assigned to individual savings and 7.5 percent is assigned to ACO savings. The cost of care for cases below target for each provide
 or display purposes, patient encounter volume is estimated for each subgroup as equally distributed. From the COPP pool apportioned to teamwor
 individual allocation is based on individual scorecard performance within the specialty.
 to this subgroup based on patient encounters, 50 percent is shared among the PCPs and 10 percent among the anesthesiologists, and 10 perce
 to this subgroup based on patient encounters, 70 percent is shared among the PCPs, 20 percent among the anesthesiologists, and 10 percent arr
 his subgroup based on patient encounters, 30 percent is shared among the PCPs, 20 percent among the anesthesiologists, and 10 percent amon
 idual scorecard results relative to aggregate outcomes scores.
 s, discharge physicians, and anesthesiologists, with specialty attribution based on episodes of care by specialty and individual attribution based or

A MERIT-BASED SHARED SAVINGS DISTRIBUTION MODEL

WE CARE ACO - HYPOTHETICAL
Summary of Shared Savings Distributions to Physicians (1)

Provider Class	Provider Specialty	ED Overuse Initiative
Physician		
	Anesthesiology	\$ -
	Cardiology	-
	Discharge Physician	-
	Endocrinology	-
	Nephrology	-
	Primary Care	4,000,000
	Pulmonology	-
	Totals, All Providers	\$ 4,000,000

Notes:

(1) Hypothetical example only. Amounts and percentages reported in the example are

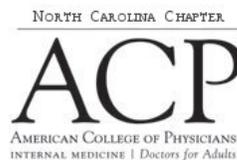
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WE CARE ACO - HYPOTHETICAL (continued)
Summary of Shared Savings Distributions to Physicians (1)

Complex Obese Patient Project					
Individual Process Measures	Teamwork Measures	Outcomes Measures	Transitions Management	Totals	Aggregate Shared Savings
\$ 168,199	\$ 210,000	\$ 182,644	\$ 183,653	\$ 744,496	\$ 744,496
80,572	70,000	87,913	-	238,485	238,485
179,995	70,000	168,231	151,784	570,010	570,010
101,490	70,000	98,135	-	269,625	269,625
91,831	70,000	85,511	-	247,342	247,342
280,142	840,000	283,264	264,563	1,667,969	5,667,969
97,771	70,000	94,302	-	262,073	262,073
\$ 1,000,000	\$ 1,400,000	\$ 1,000,000	\$ 600,000	\$ 4,000,000	\$ 8,000,000

presented for illustration only and cannot be relied upon as indicative of expected results.

ACKNOWLEDGMENT



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