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Shared Savings for Medicaid Accountable Care Organizations: Design Considerations

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IN BRIEF

Shared savings contracts provide a critical foundation for Medicaid accountable care organization (ACO) programs. These financial arrangements define how ACO providers can benefit financially if they maintain or improve their patients' health for lower cost. Calculating an appropriate shared savings approach, thus, is an integral step toward achieving a more accountable approach to care delivery. This technical assistance tool, made possible by The Commonwealth Fund, draws from the experiences of states that have successfully implemented shared savings arrangements in their Medicaid ACO programs as well as research on how shared savings arrangements operate. It outlines key factors in designing a shared savings ACO approach: (1) minimum population; (2) total cost of care benchmark; (3) truncation of costs/member carve-out; (4) risk transitions; (5) minimum savings loss rates; (6) maximum savings loss rates; and (7) performance limits.

The shared savings contract is a cornerstone in the early development of a Medicaid accountable care organization (ACO) program. A shared savings arrangement allows providers to benefit financially if they maintain or improve their patients' health for lower cost. Providers participating in a shared savings arrangement typically have an opportunity to share in savings if their attributed population uses a less costly set of health care resources than a predetermined baseline (the "upside"). In some cases, providers can transition over time to share the financial risk of providing more costly services (the "downside"), whereby they would have to pay the state or payer back a percentage of costs if they exceed baseline numbers. Skimping on care to reduce the costs of caring for their attributed beneficiaries is deterred through the collection and analysis of quality measures.

Over the last four years, the Center for Health Care Strategies' *Medicaid ACO Learning Collaborative*, made possible with support from The Commonwealth Fund, has brought together state officials and leading experts to help design and implement Medicaid ACO programs. This technical assistance tool draws upon the experiences of states that have successfully implemented shared savings arrangements in their Medicaid ACO programs as well as research on how shared savings arrangements operate. It outlines key factors that must be addressed in designing a shared savings ACO approach:

1. **Minimum Population** – the required number of enrollees for an ACO to be able to manage risk;
2. **Total Cost of Care Benchmark** – the projected cost estimate used to assess whether the ACO has generated savings and/or incurred losses during the performance year;
3. **Truncation of Costs / Member Carve-Ou**t – the exclusion of certain enrollees or costs;
4. **Risk Transitions** – whether the program allows for greater opportunity for savings and risk in later years of operation;
5. **Minimum Savings Loss/Rates** – the minimum amount of variation that attributes savings or loss to the ACO;
6. **Maximum Savings Loss/Rates** – the percentage of the savings or risk in which the state allows ACOs to share;
7. **Performance Limits** – the total amount of potential shared savings or loss that can be realized.

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The Problem of Uncertainty

The management of risk is essentially a question of uncertainty, and the questions that must be answered focus on projecting the costs of enrollees' care and minimizing the introduction of additional uncertainty through the shared savings calculations. All patients' needs over time are unknown, but can be estimated and, to some extent, managed by health care providers. Since Medicaid ACOs are financially accountable for their attributed population's medical costs, minimizing variation in attributed population's health care costs is a goal of state policymakers. By minimizing that variation, policymakers can ensure that ACOs are financially accountable for the impact of their own activities. The considerations outlined in this tool are designed to help states design an ACO program that supports ACOs' efforts to manage risk.

1. Minimum Population

The number of patients attributed to an ACO is an important factor in managing the associated financial risk of a shared savings arrangement. Enrollees' health care needs fluctuate from year to year, often randomly, and if an ACO has too few members, those variations can cause differences between actual and baseline costs that are not properly attributed to the efforts of the ACO.[1] Larger ACO populations, for example, help spread risk across a broader group of attributed patients and reduce uncertainty in future medical costs, but ACOs often need to estimate risk for smaller population sizes.

In response, some states are including minimum population requirements for their ACO programs:

State	Examples
Maine Accountable Communities (ACs)	Requires at least 1,000 members for upside-only, Model 1 ACOs. Requires at least 2,000 members for upside and downside Model 2 ACOs.
Minnesota Integrated Health Partnerships (IHPs)	Requires at least 2,000 members for "Integrated" IHPs that permit downside risk. Requires at least 1,000 members for "virtual" IHPs that only allow for upside risk.
Vermont Medicaid Shared Savings Program	Requires at least 5,000 lives, for both Track 1 (only upside) and Track 2 (upside and downside risk) ACOs.

2. Total Cost of Care Benchmark

Shared savings arrangements compare the costs incurred by the ACO to a benchmark value to determine whether the ACO has spent more or less than projected. That benchmark value is typically derived from prior health care spending, either regionally or specific to the ACO's population. Calculating the "final" total cost of care (TCoC) benchmark may involve: (1) risk adjustment; (2) price normalization; (3) policy changes; and (4) other factors expected to affect future costs. If a state decides to use prior expenditures to develop a benchmark, it must determine how to calculate the past spending to develop the benchmark. In the Medicare Shared Savings Program (MSSP), CMS uses expenditures from three previous years to calculate the benchmark. CMS initially put more weight toward recent years, but now weighs each of them equally to avoid penalizing recent successes in ACO cost reduction and encourage continued participation in MSSP.

One complication with historical benchmarking is that it can introduce some uncertainty into the shared savings calculation. For example, if the TCoC benchmark includes the cost data from the previous year, an ACO will likely be unaware of the comparison point until more than halfway through the performance year due to the time needed to capture and process health care claims data. A state could reduce this uncertainty by instead selecting a set, predetermined cost growth target (e.g., $100 per member per year) that is drawn from historical data and inform ACOs that they will share savings if their costs are lower than the target, and share costs if they are higher, though no states have yet done this. Following are examples of several existing programs' TCoC ACO benchmarks:

State	Examples
Maine ACs	One-year base period, calculated from the fee-for-service costs of the attributed population.
Minnesota IHPs	One-year base period, TCoC calculated from the cost of the core services in the past year rendered to the attributed population.
MSSP Initial Benchmarking Rule	Three-year base period, weighted as follows: ■ First year: 10% ■ Second year: 30% ■ Third year: 60%
MSSP Revision of the Benchmarking Rule[2] (2015)	Three-year base period, weighted equally, factors in regional performance

3. Truncation of Cost / Population Carve Outs

In addition to limiting the savings or risk from ACOs' entire attributed populations, states must decide whether to exclude certain types of risk from the TCoC calculations. In any population, there are certain individuals whose extreme costs are not properly attributable to the efforts of the ACO – for example, high costs from random trauma events like an automobile accident are not avoidable nor amenable to care coordination or other activities that ACOs undertake. ACOs should not be penalized for providing the proper levels of care intensity for those patients.

Accordingly, many states truncate the total cost that such high-cost enrollees incur to prevent penalizing their ACOs for unavoidable losses. Conversely, New Jersey's Medicaid ACO program was designed specifically around in-state providers' efforts for addressing the highest-need, highest-cost patients, and did not require the truncation of cost in its ACOs' shared savings arrangements. The Rutgers University Center for State Health Policy, which was tasked with developing recommendations for New Jersey ACOs' shared savings arrangements, published a report in which it noted that truncation could unfairly disadvantage programs focusing on high users so they may wish to consider not truncating.[3] Not doing so could, however, increase statistical variation that is unrelated to the effectiveness of care management, a trade off that needs to be taken into account. Below are examples of state TCoC carve-out approaches:

State	Carve Outs
Maine ACs	Members' TCoC will not include total annual claim costs by ACO size: ■ ACs with 1,000-1,999 members: costs in excess of $50,000 total annual claims ■ ACs with 2,000-4,999 members: costs in excess of $150,000 total annual claims ■ ACs with 5,000+ members: costs in excess of $200,000 total annual claims
Vermont Medicaid Shared Savings Program	Truncates the expenditures of members whose expenditures exceed the 99th percentile of members; that member's expenditures are truncated so that their total expenditures will equal the value set at the 99th percentile.

4. Risk Transitions

One of the factors that determines whether an ACO is successful at increasing quality and saving costs is whether the organization has experience in other advanced payment methodologies.[4] A state may choose to introduce a shared savings-based Medicaid ACO program by phasing risk in gradually, so by the time ACOs are taking on downside risk, they have experience managing the total cost of care. If a state requires downside risk at the outset, this may dissuade organizations that want to participate in a Medicaid ACO

program but are wary of their ability to take on risk immediately. Several Medicaid ACO states have implemented risk transitions into their ACO programs to help organizations assume risk gradually:

State	Risk Transition
Maine ACs	For Model 1 ACs (upside savings only) – no transition. For Model 2 ACs (upside savings and downside risk), the program transitions in downside risk over three years: ■ Year 1: no downside risk ■ Year 2: 5% of total benchmark expenditures ■ Year 3: 10% of total benchmark expenditures
Minnesota IHPs	Transition from upside to downside risk for "Integrated" model: ■ Year 1: no downside ■ Year 2: the IHP can choose downside risk, 2:1 risk threshold, up to 15% of total benchmark expenditures ■ Year 3: downside risk, symmetrical thresholds, up to 15% of total benchmark expenditures
Vermont Medicaid Shared Savings Program	Offers multiple tracks for Medicaid ACOs – one upside-only (Track 1) and one with downside risk (Track 2). Additionally, the program transitions the exposure of Track 2 Medicaid ACOs to downside risk, increasing that exposure over three years: ■ Year 1: 5% of total benchmark expenditures ■ Year 2: 7.5% of total benchmark expenditures ■ Year 3: 10% of total benchmark expenditures

5. Minimum Savings/Loss Rates

Another element to managing ACO risk is the establishment of minimum savings rates (MSR). Minor variation in attributed population's health care costs can result from random variation, so states can limit ACOs' savings and risk to only those amounts that exceed MSR or minimum loss rates (MLR). This is based on the assumption that larger cost savings will more likely be related to the ACOs' efforts. For example, if a state establishes an MSR of two percent, ACOs will only be eligible for shared savings or responsible for losses if their total difference from baseline exceeds two percent. The state may then offer shared savings *in excess* of the MSR, so ACOs share in whatever savings or risk exceed the baseline plus the MSR. Alternately, the state can offer "first dollar" savings whereby if an ACO's performance exceeds the MSR, then all savings above the baseline are shared.

State	Examples
Maine ACs	Varies by size of AC: ■ For ACs with 1,000 to 4,999 members, savings must meet or exceed 2.5% of the total cost of care; ■ For ACs with 5,000 or more members, savings or losses must meet or exceed 2% of the total cost of care
Minnesota IHPs	2% of total cost of care: ■ For an integrated IHP, the performance TCoC must be above 102% or below 98% of the adjusted TCoC target for shared losses or shared savings payments to occur; ■ For a virtual IHP, the performance TCoC must be below 98% of the adjusted TCoC target for shared savings payments to occur.
Vermont Medicaid Shared Savings Program	2% of total cost of care

6. Maximum Savings/Loss Rates

States can also design their shared savings programs to provide for different levels of savings and risk for ACOs that realize savings or losses, providing a maximum percentage of realized savings from the savings pool. States may also elect to provide for "asymmetrical" maximum savings and loss rates, which provide more upside than downside, creating an incentive for organizations to participate in the program. For example, a state could allow for ACOs to share in up to 70 percent of any savings realized, but only be responsible for 50 percent of the potential downside risk. Finally, states can limit the total amount of difference between actual and benchmark spending that can be shared between the state and the ACO in what is known as a risk corridor.

State	Examples
Maine ACs	For Model 1 ACOs (upside savings only) – up to 50% of upside savings, based on quality performance. For Model 2 ACOs (upside savings and downside risk): ■ Year 1 – no downside risk, can share in up to 60% of savings, based on quality performance; ■ Years 2 & 3 – up to 60% of savings or losses, based on quality performance.
Minnesota IHPs	For "integrated" IHPs, the shared savings and loss rate may be up to 85%, but it is negotiated between the IHP and the state. For "virtual" IHPs (upside savings only), IHPs can share in up to 50% of savings.

7. Performance Limits

Policymakers must also decide whether there will be limits or "caps" on the maximum amount of upside shared savings or downside shared risk for their Medicaid ACOs. A state has an interest in limiting the total potential savings and losses because of the uncertainty in enrollees' total cost of care – ACOs should not see a windfall beyond a certain, pre-determined amount because of factors outside of their control, and likewise ACOs should not be put in extreme financial risk.

To encourage participation in ACO programs, state policymakers can allow ACOs to share in more upside savings vs. downside risk. ACOs will be more likely to participate if they can realize more savings than they do risk in an "asymmetrical" system. Several states incorporate asymmetrical risk sharing with the transitioning in of risk, as detailed earlier.

State	Examples
Maine ACs	For Model 1 ACs (upside savings only) – 10% of total benchmark TCoC. For Model 2 ACs (upside savings and downside risk), a phased transition: ■ Year 1 – Upside only, 15% of total benchmark TCoC limit ■ Year 2 – Upside limit 15% of total benchmark TCoC; downside limit 5% of total benchmark TCoC ■ Year 3 – Upside limit 15% of total benchmark TCoC; downside limit 10% of total benchmark TCoC
Minnesota IHPs	For "integrated" IHPs, the performance limit transitions over time: ■ Year 1 – upside only, selected by IHP, up to 15% ■ Year 2 – 2:1 savings/risk limits, selected by IHP, up to 15% ■ Year 3 – symmetrical savings/risk limits, selected by IHP, up to 15% For "virtual" IHPs, no performance limit.

Looking Forward

Shared savings arrangements are recognized as one type of value-based purchasing model, and a number of states have successfully used such arrangements in their Medicaid ACO programs. Given the structure of shared savings arrangements, there are concerns on the part of providers that savings may be more difficult to realize over long time-periods, as processes are improved and care coordination is implemented more broadly in participating organizations. Other organizations view shared savings arrangements more positively, as an "on-ramp" or "training wheels" to move providers away from fee-for-service payment.[5]

Going forward, the federal Medicare Next Generation ACO program[6] and Vermont's All-Payer ACO[7] are offering providers and ACOs prospective payment and capitation as a way to support value-driven payment. An effectively designed shared savings program allows organizations to learn how to measure quality and manage the total cost of care, providing them with experience in value-based payment methods to improve their capacity and accountability for delivering high-quality, cost-effective care for their patients.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ADDITIONAL RESOURCES

State-based Medicaid ACOs are becoming increasingly prevalent, with more states pursuing this model as a way to improve health outcomes and control costs. CHCS' Medicaid Accountable Care Organization Resource Center, made possible through The Commonwealth Fund, houses practical resources to help states design, implement, and refine ACO programs. Visit www.chcs.org/aco-resource-center.

ENDNOTES

[1] D. DeLia. "Leaving it to Chance: The Effects of Random Variation in Shared Savings Arrangements." *Health Services & Outcomes Research Methodology*, November 2013, 13:2-4, pp. 219-240.

[2] Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations; Final Rule (81 FR37949, June 10, 2016). Centers for Medicare & Medicaid Services. Available at: https://www.federalregister.gov/documents/2016/06/10/2016-13651/medicare-program-medicare-shared-savings-program-accountable-care-organizations-revised-benchmark.

[3] D. DeLia and J. Cantor. *Recommended Approach for Calculating Savings in the New Jersey Medicaid ACO Demonstration Project*. Rutgers Center for State Health Policy, July 2012. Available at: http://www.cshp.rutgers.edu/publications/recommended-approach-for-calculating-savings-in-the-nj-medicaid-aco-demonstration-project-3

[4] D. Muhlenstein, R. Saunders, and M. McClellan. "Medicare Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues." *Health Affairs Blog*, September 9, 2016; see also D. Peiris, et al. "ACOs Holding Commercial Contracts are Larger and More Efficient than Noncommercial ACOs." *Health Affairs,* 2016, no. 10: 1849-1856.

[5] R. Berenson, D. Upadhyay, S. F. Delbanco, and R. Murray. *Payment Methods: How They Work*. Urban Institute, May 2016. Available at: http://www.urban.org/research/publication/payment-methods-how-they-work

[6] Next Generation ACO Model - Financial & Alignment Frequently Asked Questions. Available at: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/nextgenaco-fnclalgnfaqs.html.

[7] Vermont All-Payer ACO Model. Available at: https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/.