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Shared Savings Distribution Models in Medicare ACOs: A First Look

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Hospitals have traditionally been unable to share savings with independent physicians for fear of setting off legal alarm bells—Stark, anti-kickback, and private inurement. This concept was so hardwired into the minds of health system executives that when some exceptions became possible through Medicare accountable care and bundled payment programs, everyone was skeptical.

Now, the first Medicare Shared Savings Program (MSSP) ACOs are beginning to publicly report how their shared savings distribution models will work. Everyone (whether operating an MSSP ACO or not) is watching with interest. Of course, we are not yet talking about the distribution of actual shared savings, but rather how any shared savings that materialize would be distributed. With nearly 70 ACOs disclosing their distribution models on their websites, we can begin to make some initial observations regarding early MSSP ACOs.

FOCUS ON INFRASTRUCTURE

For many of the ACOs, infrastructure comes first: Eighty-five percent of the ACOs report that their distribution plan either covers operating expenses first or reinvests in infrastructure first. The latter is more common. For those reporting that they will reinvest in infrastructure, about one-third of shared savings will be reinvested.

DISTRIBUTION PATTERNS

Of the two-thirds of shared savings that will be distributed to ACO participants (providers in the network, e.g., hospitals, physicians), the break down among MSSP ACOS will be as follows.

Physicians.

Primary care physicians will get more than half of distributions to providers (70 percent in physician-only ACOs and 50 percent in hospital-physician ACOs); specialists will get 15 to 20 percent.

Hospitals.

Hospitals will get very little unless they are partners in the ACO. Hospitals get 30 percent when they are the leading partners in a collaborative ACO, but only 5 percent when they are part of a physician-sponsored ACO. Clearly, hospitals that want to partially offset patient care volume reductions with their portion of shared savings will take note of this.

Others.

The remaining 5 percent goes to a combination of shareholders, investors, or other stakeholders in both models.

It is too early to tell if the size of the ACO (number of physicians or covered lives) influences the distribution model or if there are regional differences.

The real test will occur when the actual shared savings amounts are announced.

IMPLICATIONS FOR HOSPITAL ACOs

As hospitals move to form clinically integrated networks (CINs) that take on new payment models, these findings can provide useful guidance. For instance, the most common approach to distributing shared savings in CINs in the past was to cover operating expenses and then sharing savings 50/50 between hospitals and physicians. The average split in the MSSP seems more like 30/65, with a little going elsewhere.

The real test will occur when the actual shared savings amounts are announced and it becomes apparent which types of ACOs are really generating the most shared savings. The early shared savings amounts may be a useful indicator of whether physician-only ACOs will become the wave of the future or whether hospitals have a winning strategy for engaging primary care physicians.

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