COPE HEALTH SOLUTIONS

Making Shared Savings Work

Six Strategic Decisions for ACO Incentive Design

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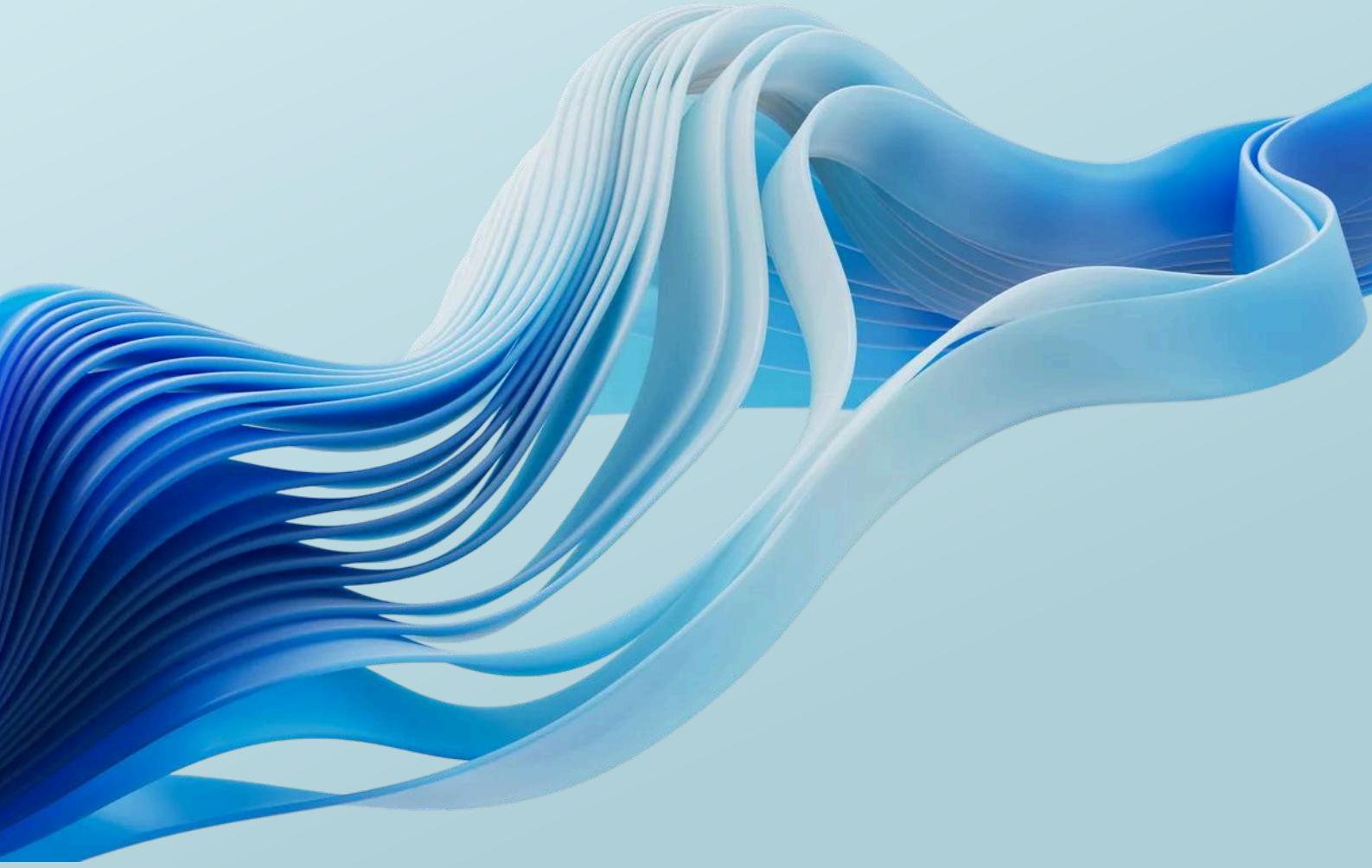

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Introduction

Designing a shared savings distribution model is one of the most strategic (and at times politically sensitive) decisions an Accountable Care Organization (ACO) can make. Your ACO's incentive structure tells prospective participants a lot about your values, priorities, and performance expectations and is a critical differentiator in attracting physician groups.

There's no universal right model. But there is a right process: start with key decision points, model out scenarios that reflect your reality, and engage stakeholders early.

This paper lays out six core design decisions every ACO should consider in structuring its shared savings distribution strategy. Each section offers guiding questions, trade-offs, and potential approaches. Use it to stress-test your current model or as a blueprint for launching something new.

CONSIDERATION 01

First Dollar Savings? Who Gets Paid First?

The first design choice is whether to distribute shared savings from dollar one or only after the ACO recoups operational costs.

Key Questions

- Do we need to reserve funds for infrastructure, staffing, or technology?
- Will participants support a model that prioritizes ACO sustainability over physician distribution?
- Can we build a phased or tiered structure that adapts based on savings level?

Practical Trade-Offs

- Distribute from dollar one: Motivates participants but may underfund ACO functions.
- Recoup costs first: Ensures long-term viability, but risks disengagement if participants perceive the model as overly cautious or opaque.
- Tiered models: Allow for both cost recovery up front, with growing incentives as performance improves.

Example

Hudson ACO implements a five-tier model, where the first $999K of savings covers ACO costs. As savings increase, different classes of providers (PCPs, specialists, care team members) become eligible for bonuses.

See Table 1.

This model was transparent, predictable, and aligned with Hudson's phased growth strategy.

CONSIDERATION 02

Am I Able to Fund In-Flight Incentives? If so, How?

Financial Settlement in MSSP and ACO REACH doesn't happen until roughly 9 months after the performance year ends (sometimes longer). This delayed payment can be a substantial problem for providers who are operating at an already thin margin. Factoring in a potential CMS delay and several weeks of processing on the ACO's side (where "processing" is defined as the ACO collecting, dividing up, and distributing shared savings to recipients), shared savings recipients are realistically looking at a roughly two-year lag from when they join an ACO to when they are rewarded for their hard work.

Most ACOs don't have the necessary reserves to fund in-flight incentives for participating providers.

For those that do and/or took advantage of enhanced payments in ACO REACH, the incentives are

TABLE 1

Hudson ACO's Tiered Incentive Model

Tier	Shared Savings Range	Recipients	Example
1	$0 - $999K	None	ACO keeps any shared savings up to $999K to partially recoup infrastructure costs
2	$1M - $2.99M	PCPs only	Hudson has 120 PCPs participating in its MSSP. It generates $2.5M in shared savings. The $1.5M bonus pool is divided up equally amongst the PCPs equating to a pre-tax bonus of $12,500 per PCP
3	$3M - $4.99M	Specialists	In addition to the 120 Participant PCPs, Hudson has 150 specialists participating in the MSSP. Assuming Hudson achieves shared savings of $4.5M: The first $999K stays with the ACO, the next $2M is distributed to PCPs, the next roughly $1.5M would go to the specialists. Thus, in a scenario where the ACO achieves $4.5M in shared savings, the bonus pool for the specialists is approximately $1.5M, which equates to a pre-tax bonus of about $10,000.
4	$5M - $6.99M	APRNs, Care Managers, CHWs, Social Workers, PHMs	In addition to the 120 PCPs and 150 specialists participating in the MSSP, there are 210 APRNs working with the participating PCPs and 25 ACO-specific staff (20 Care managers, 3 Social Workers, a community healthcare worker and one Population Health Manager). The APRNs and ACO staff are not listed as participants or preferred providers in the MSSP but they play an integral part in its overall success. Therefore, any savings between $5M-$7M is distributed to them. For example, if Hudson generates $6M in shared savings, that will create a $1M bonus pool to be distributed evenly amongst the aforementioned staff. This $1M equates to a roughly $4255 pre-tax bonus per person.
5	$7M+	ACO Profit	In an extremely bullish scenario where the ACO saves more than $7M dollars, all savings above the $7M threshold are retained by the ACO.

usually mis-spent. Signing bonuses, paying 20% above Medicare rates for each claim, incentive payments to use the ACO's / VBC Enabler Company's technology platform, etc. In addition to being extremely expensive, such incentive structures reward participation instead of performance.

Example
A more thoughtful approach can be seen in the approach taken by St. Lawrence ACO.

St. Lawrence has developed both an "in-flight" incentive system and a "year-end" incentive structure. The

TABLE 2

St. Lawrence's In-Flight Incentive System

Initiative	Target	Incentive Structure
Incorporate "open access" times in practices' schedules to encourage impromptu patient visits	20% of daily schedule reserved for "open access" appt. Binary Target: Achieved or not achieved	Each physician who meets the 20% threshold for the full quarter will receive $3 PBPM for each of his/her ACO-aligned beneficiaries. E.G. A PCP with 100 MSSP benes in their panel will receive $900 a quarter or $3600 a year
Expanding Office Hours beyond 8-5	Keep the office open two Saturdays a month for a half-day	Each practice that meets the target will receive $3 PBPM each quarter commensurate with the number of MSSP benes in their panel
Establish 3-day follow ups with physicians post-hospital, ER or SNF visit	85% of relevant patients seen within 3 days of discharge	Each physician who meets the 85% threshold will receive $3 PBPM for each of his/her ACO-aligned benes

ACO used shared savings generated in the first two years of their MSSP agreement period to implement and fund their current in-flight incentive system. The in-flight incentive system works in the following way:

St. Lawrence has delineated three major initiatives that it wants its PCPs to pursue. However, PCPs are only expected to pursue 2 of the 3 initiatives. The doctors select which two of three to pursue. A PCP that achieves one of the two selected objectives is rewarded each quarter with $3 PBPM reflecting the number of ACO beneficiaries in their panel. If the PCP meets their targets on both initiatives, that PCP is given the full $6 PBPM.

Table 2 illustrates this "in-flight" incentive system in further detail.

Any money not distributed via the "in-flight" mechanism above remains with the ACO. St. Lawrence is very focused on increased PCP access as a means of keeping beneficiaries out of high-cost sites of care. Leadership not only wants to keep the focus simple but also to ensure that the incentive pool isn't so scattered across multiple different initiatives that the rewards are too small to motivate. For these reasons, St. Lawrence created the narrowly focused, "in flight" incentive distribution mechanism in Table 2.

As for actual shared savings achieved through the MSSP model, St. Lawrence treats these shared savings in the manner displayed in Table 3.

TABLE 3

St. Lawrence's Secondary, End of Year Distribution Structure

Tier	Shared Savings Range	Recipients	Example
1	$0 - $1.99M	None	St. Lawrence keeps any shared savings up to $1.99M to cover operational costs
2	$2M - 2.75M	Highest Performing PCPs	Tier II consists of up to $750k to potentially be distributed to the highest performing PCPs. Specifically, the in-flight system only rewards physicians for achievement of 2 of the potential 3 PCP access initiatives. PCPs that participate in and hit their targets relevant to all 3 initiatives will be given a supplemental rewarded using this pool of year-end shared savings
3	$2.76M +	ACO Retains	St. Lawrence plans to reinvest any savings above $2.75M back into the ACO to fund future in-flight incentive systems specific to focus areas for the year

CONSIDERATION 03

Should the Model Evolve Over Time?

Just as an ACO matures in both infrastructure and appetite for risk, its incentive structure should evolve with it.

ACOs that are further along the path of taking downside risk on behalf of their participants should necessarily have different incentive structures than those just entering upside arrangements – performance should be the emphasis of mature incentive structures.

Early on, it may be enough to simply reward participation or attributed volume. But over time, this approach runs the risk of disengaging high performers or under-incentivizing strategic behaviors. Many ACOs stall out in Years 3–5 because their distribution model fails to evolve with their capabilities: high performers disengage, benchmarks tighten, and the ACO can no longer compete with more sophisticated peers. A dynamic model allows your ACO to mature with intention, aligning incentives to your evolving goals.

Key Questions

- Where are we on the value-based care maturity curve?
- Are our participating provider groups ready to be held accountable for performance?
- Do we anticipate major changes in contract terms, benchmarks, or attribution?

This phased approach helps balance equity and performance. It also gives participants time to prepare, both operationally and culturally, for increasing levels of accountability. When rolling out a new incentive structure, the ACO should provide 6-12 months' notice and offer practice-level data reports so provider groups can track their own performance in advance.

Some ACOs also use this evolution path to introduce non-monetary investments, such as:

- Targeted grants for care teams

TABLE 4

Incentive Design by ACO Maturity

ACO Maturity	Distribution Strategy	Focus
Startup: Year 1-2	Flat per-attributed-life or participation-based distribution	Build trust, establish buy-in
Growth: Year 3-4	Layer in performance thresholds (e.g. ED/1000, readmissions rate) or engagement requirements	Align incentives to performance
Mature: Year 5+	Introduce benchmarks, differential payouts, reinvestment funds, innovation pools	Drive continuous improvement and innovation

- Funds for technology enhancements
- Support for new services (e.g., community health workers)

CONSIDERATION 04

Win as a Team or Reward Individual Performance?

This is one of the most fundamental choices in incentive design: should savings be distributed equally across all participants based on attribution, or selectively based on performance?

Win as a Team

- Emphasizes collaboration and shared accountability
- Helps level the playing field for under-resourced groups
- Easier to calculate and administer incentive pay-out
- Risk: High performers may feel under-rewarded

Reward High Performers

- Drives measurable improvement
- Rewards clinical excellence and efficiency
- Risk: may discourage participation from groups that lag in performance or resource

While the Hudson ACO example from earlier provided an example of a "win as a team" approach to shared savings distribution, the example below from "Westwood" ACO offers that rewards high performing physician practices.

Example
Westwood ACO is comprised of 20 participating entities, each with an individual tax identification number (TINS) as their participation identifier. 14 of the TINS are owned by the Westwood Health System while the other 6 are independent practices. The smallest TIN consists of 10 physicians while the largest consists of 50 physicians. Like Hudson ACO, Westwood utilizes a tiered incentive structure. Westwood, however, doesn't quite buy into the "win as a team, lose as a team" philosophy – they want to reward high performers and have elected to align the tiered incentive structure to performance against specific population health initiatives.

Table 5 illustrates Westwood's Shared Savings distribution structure in greater depth.

CONSIDERATION 05

What if it Wasn't Just About Money?

Not every distribution model needs to focus on direct provider payments. For organizations, reinvesting in people, tools, or the community has more long-term value than checks in the mail.

Creative Uses of Shared Savings

- Hire additional care coordinators, social workers, or support staff
- Fund ride-share or Activities of Daily Living (ADL) programs for vulnerable patients
- Upgrade EMR systems or data infrastructure
- Support trusted community organizations serving high-need populations
- Stand up mobile health units to provide rotating primary care or behavioral health access in underserved zip codes
- Pilot a remote patient monitoring program for high-risk patients with CHF, COPD, or diabetes
- Subsidize training for medical assistants or CHWs to specialize in behavioral health or care navigation
- Launch a burnout mitigation program: wellness stipends, mental health support, flexible scheduling pilots

For ACOs built around mission-driven participants – like community health centers or federally qualified health centers (FQHCs) - this approach can boost morale, address social

TABLE 5

Westwood's Tiered Distribution Approach Rewards High-Performers

Tier	Shared Savings Range	Recipients	Example
1	$0 - $2.99M	None	ACO keeps any shared savings up to 2.99M to recoup infrastructure costs including an $800k premium paid to a reinsurance company brought in for downside protection.
2	$3M - 4M	Top 5 Performing TINs on ED Visits / 1000 Metrics	Assuming Westwood earns $4M in shared savings, $1M dollars will be distributed to the 5 TINs with the best ED Visits / 1000 rate. The amount of the distribution will be commensurate with panel size. In other words, if TIN X features 5000 ACO-aligned beneficiaries and TIN Y features 1000 ACO-aligned benes, TIN X will receive 5x as much money as TIN Y. Westwood has also decided that there will be no difference between coming in first vs. fifth as far as the amount of savings distributed.
3	$4.01M - $5M	Top 5 performing TINs on Readmissions Percentage	Tier 3 provides for up to a $999k bonus pool to reward practices with the lowest readmit rates.
4	$5.01M+	Future Incentives Pool	Westwood will retain shared savings above $5.01M to fund future incentives. ACO leadership doesn't like the fact that financial reconciliation in MSSP doesn't happen until almost 9 months after the end of the PY. Thus, if the ACO achieves savings in excess of $5.01M, it plans to use that money for quarterly incentive payments during the 2027 PY.

determinants, and deepen community trust. Even if your ACO isn't able to donate to the community or re-invest back into provider practice transformation at a "first dollar saved" rate, structuring and committing to creative distribution types is an underestimated way to appeal to providers who are inherently altruistic.

CONSIDERATION 06

Should We Crowdsource the Strategy?

Rather than designing the entire model from the top down, some ACOs ask participants to help shape how savings are used.

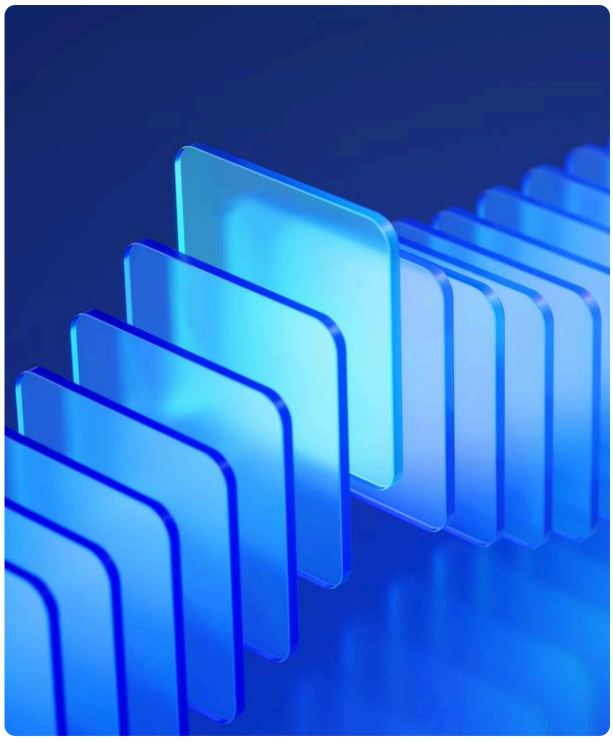
Benefits of Crowdsourcing

- Generates buy-in from participating provider groups
- Surfaces creative ideas leadership may not anticipate
- Increases transparency and engagement

Example

"James River" ACO creates a two-stage voting process. Participants first submit non-monetary investment ideas (e.g., EMR enhancements, wellness initiatives), then vote on the final allocation of savings beyond the initial threshold.

James River ACO likes the idea of a tiered approach to shared savings distribution. ACO leadership has made it clear to ACO participants that the first $2M worth of achieved shared savings will go back to the ACO to recoup programmatic costs. This first $2M is considered "Tier 1". However, James River leaves any shared savings above the $2M threshold up to the discretion of its ACO Participants. James River institutes a European, Parliamentary type voting system wherein there are two rounds of voting. In the first round, ACO leadership asks participants to submit one project or idea for shared savings distribution that would cost under $500k and be implementable within a reasonable time frame (important note: participants are explicitly told that direct financial distributions are not an option). The ACO reviews submitted ideas and selects the 10 most frequently mentioned projects ideas for a second round of voting. The most popular ideas form the next set of tiers. For example, if after the second round of voting the most popular idea is to invest in a specific EMR enhancement, the first set of available funds above the $2M dollars will be allocated toward the EMR enhancement. The EMR enhancement project will thus become "Tier 2". Tiers 3, 4, 5 etc. will be allocated toward the third, fourth and fifth most popular ideas / project respectively.



Conclusion & Next Steps

There's no off-the-shelf shared savings model that fits every ACO. The right distribution strategy depends on your finances, structure, performance history, and values. What matters is that you make intentional, transparent decisions and revisit them as your organization evolves.

COPE Health Solutions can partner with ACOs and provider networks to:

- Model distribution strategies across scenarios
- Facilitate provider engagement and governance alignment
- Implement performance dashboards and attribution analytics
- Support operational execution of the incentive model

Let's Design Smarter Shared Savings Models - Together.

If you're ready to rethink your incentive structure or launch a new one – reach out to the COPE Health Solutions team today at **info@copehealthsolutions.com** or directly to our ACO experts:

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