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Issue Brief

Key Design Elements of Shared-Savings Payment Arrangements

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ABSTRACT: Shared savings is a payment strategy that offers incentives for providers to reduce health care spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts. The concept has attracted great interest, in part fueled by Affordable Care Act provisions that create accountable care organizations and by the movement among medical home pilots to make payment methodologies more performance-based. In this issue brief, the authors interviewed payer and provider organizations and state agencies involved in shared-savings arrangements about their diverse approaches, including the populations and services covered, the assignment of providers, the use of risk adjustment, and the way savings are calculated and distributed. The authors identified issues payers and providers must resolve going forward, including determining whether savings were achieved, equipping providers with necessary tools and technical advice, agreeing upon standard performance measures, and refining the model over time.

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OVERVIEW

Shared savings is a payment strategy that offers incentives for provider entities to reduce health care spending for a defined patient population by offering them a percentage of any net savings realized as a result of their efforts. Shared savings can be applied to some or all of the services that are expected to be used by a patient population. The concept has attracted great interest in 2011, in part fueled by provisions within the Patient Protection and Affordable Care Act that create accountable care organizations (ACOs).

Specifically, the creation of the Medicare Shared Savings Program for ACOs, beginning in 2012, calls for shared savings as a primary payment methodology. This prompted frenzied activity among many providers to position themselves to become ACOs even before the draft rules for the program were released. Such provider organizations have taken steps to negotiate and implement shared-savings contracts with commercial insurers.

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Added interest in shared savings comes from the movement among medical home pilots to make payment methodologies more performance-based. A few early pilots have employed shared-savings approaches and others are developing or implementing plans to do so.[1]

Shared savings is not a wholly new reimbursement model. While it has not been widely used, there are existing examples of the concept in operation that predate the Affordable Care Act. Examining the characteristics of these models may increase understanding regarding how best to structure shared-savings arrangements and the decisions faced in constructing them.

In this issue brief, Bailit Health Purchasing conducted 32 telephone interviews with payer and provider organizations and state agencies that indicated they were involved in independent past, current, and planned shared-savings payment arrangements. The 27 assessed shared-savings programs were primarily applied in primary care practice medical home programs and in ACO-like payment arrangements involving a more broadly defined provider organization. Approximately one-third of the arrangements were formed through medical home or medical home-like programs. The medical home and ACO-like shared-savings models did not differ considerably in construction beyond medical home programs providing supplemental PMPM payments and ACO-like programs that did not. Approximately two-thirds of the arrangements were implemented in 2010 or 2011.

There are a few key issues which payers and providers must resolve as they design and implement shared-savings payments models. First, they must agree on how to determine whether savings were achieved so that there is both a meaningful incentive for the provider and reasonable protection that calculated savings do not reflect random variation in health care costs. This balance is difficult to achieve, especially in the case of smaller provider organizations.

Second, providers need tools to succeed if they are to transform care delivery. Payers can help provide some of these tools, including timely, trended performance data with targets and benchmarks, and giving practices the ability to manipulate such data. They can also provide technical advice regarding knowledge and implementation of systems and processes to deliver better care more efficiently. In particular, smaller provider organizations may need additional assistance, as well as those that are not in robust financial health.

Third, while testing the application of varied performance measures across payers may be of value in the near term, competing sets of performance measures in shared-savings methodologies could eventually harm the effectiveness of the payment models, as providers will find it difficult to focus. There may be opportunities for regional coalitions to identify a common framework with which nonfederal payers might align.

Finally, national expectations are high that payment and delivery system reform will finally slow the inexorable march of health care cost growth. It will be necessary to learn within and across both payer and provider organizations from the successes and failures and to maintain a resolve to persistently refine the shared-savings payment model to maximize effectiveness.

PATIENTS, SERVICES, AND PAYMENTS IN SHARED-SAVINGS MODELS

Which patient populations are included in shared-savings models?

Shared-savings arrangements vary in terms of included patient populations, depending on whether the arrangements are applied in medical home models or ACO-like models. Medical homes tend to include fully insured commercial populations in single-payer models, and fully insured commercial populations and Medicaid managed care populations in multipayer initiatives. Patients covered by self-insured employers are included under some arrangements but not others. This is because of the varying policy positions taken by third-party administrators regarding charging self-insured employers the supplemental per member per month (PMPM) payments usually made to practices under medical home pilots. Specifically, some administrators believe their administrative agreements with

self-insuring employers allow for supplemental payments to medical homes while others do not. In cases where the supplemental payments are not considered permitted under the administrative services agreement, some third-party administrators will ask self-inured employers to opt-in to such payments, some will invite employers to opt out, and others will not broach the subject with their self-insured employers. Finally, some administrators will treat different classes of self-insuring employers differently.

ACO-like shared-savings models, which do not routinely provide PMPM supplemental payments, are much more likely to include patients covered under self-insured employer contracts. These ACO-like shared-savings models are applied to a variety of different patient populations, most often including the following:

- only commercially insured and self-insured;
- only Medicare Advantage;
- commercially insured, self-insured, and Medicare Advantage, and
- traditional Medicare and/or Medicare/Medicaid dual eligibles (in the context of CMS federal demonstrations).

In some cases the payer begins the shared-savings program with one patient population and then expands to other patient populations in future years. Medicaid populations were rarely involved in the ACO-like shared-savings models, but were involved in medical home shared-savings models.

Finally, pediatric populations are excluded in some instances. This can be because of payer concern that the opportunities for savings, particularly in commercially insured populations, are not great due to the generally good health status of children.

How are providers assigned responsibility for the patient population for which savings are calculated?

For patients enrolled in a PPO product or in traditional Medicare, the patient population in almost all instances is defined by the use of a patient-attribution methodology that examines historical utilization patterns and attributes the patient to the provider entity with which the patient has the best-established care pattern. The pattern is typically assigned by determining with which practices the patient had the most primary care visits, or primary and specialty visit, for specified evaluation and management codes in the past 12, 18, or 24 months. In some cases, consideration is also given to the most recent visits, particularly in the event of a tie in the number of visits. The attribution is performed by the payer using the claim data.

For patients enrolled in an HMO product, the responsible provider is the provider entity with which the patient's selected primary care clinician is affiliated.

On occasion, shared-savings models will assess performance only for those patients who were continuously enrolled for 11 or 12 months of the year.

What services are included in the shared-savings calculation?

Most of the studied shared-savings programs assess savings relative to the full set of covered services for the patient population. These services vary depending upon the payer and the line of business; for example, commercial plan, Medicare Advantage, traditional Medicare, and Medicaid. There are programs that exclude certain services, however. Examples of excluded services include: organ transplants; prescription medications; behavioral health; pediatric services; dental services, except for limited services covered by health care coverage premium payments; out-of-area services; and nonpreventable inpatient and emergency department services.[2]

In some cases services are excluded because self-insured employers will carve services out to a specialty vendor (e.g., pharmacy), making the shared-savings calculation more challenging to perform because the benefit is administered by the insurer for some members and not others. One carrier interviewed for this study described a method to adjust for such carve-outs.

In multipayer medical home arrangements that utilize multipayer claims databases, limitations to databases can potentially limit the services that are included. For example, Maryland's multipayer database does not always contain pharmacy claim information.

What payments are excluded from the shared-savings calculation?

In addition to excluding certain patient populations and services, shared-savings arrangements commonly exclude certain types of payments. Such payments include the following categories:

Non–service-related payments. Shared-savings arrangements will exclude consideration of payments that do not relate to the direct provision of services, including:

- performance incentive payments, such as pay-for-performance bonuses;
- management fees;
- vendor-capitated payments (e.g., behavioral health, laboratory); and
- risk-contract settlements (including prior year shared-savings payments).

High-cost outliers. Shared-savings arrangements commonly remove costs related to patients with very high costs during the measurement period, which is typically 12 months. This is done by truncating the high-cost patients. The payer and provider entities define an annual per-patient expenditure level above which any medical expense will be either fully or partially excluded from the shared-savings calculation.

The dollar level at which patient-specific medical expense is truncated varies considerably. In most cases it is defined as a flat dollar amount, with an observed range of $50,000 per year to $500,000 per year. The most commonly reported truncation points were between $100,000 per year and $200,000 per year. Medical home model truncation points tend to be somewhat lower than those of the ACO-like arrangements.

While the flat dollar truncation approach is most common, there are other approaches to addressing high-cost patient outliers, including:

- making no adjustment;
- defining the truncation point in terms of standard deviation from the mean per patient annual medical expense, such as two and three standard deviation truncation points;
- varying the truncation point by patient population (e.g., commercially insured vs. Medicare Advantage) due to different patterns in spending by population;
- applying some percentage medical expense above the truncation point to the shared-saving calculation in order to motivate the provider to continue to engage in care management after the patient exceeds the threshold; and
- truncating based on utilization measures rather than cost measures (e.g., costs associated with inpatient stays in excess of 20 days).

In cases in which high-cost medical expenses are truncated, the payer either removes the value of those claims from the target being used for savings calculation or the payer "charges back" the cost of reinsuring the provider for purposes of shared-savings calculations.

Finally, on rare occasions, low-cost outliers are also excluded for the savings calculation. The implication of this practice on savings determinations is unclear.

How are supplemental payments and vendor-capitated payments treated in shared-savings calculations?

Supplemental PMPM payments are common in medical home payment models. These payments are typically netted out as expenses in shared-saving calculations.

Vendor-capitated payments for services such as behavioral health or laboratory services are treated in one of two ways. The payments and associated

services may be excluded altogether from the calculation. Alternatively, encounter data submitted by the capitated vendor can be priced per unit of service and included in the calculations.

SPECIAL ADJUSTMENTS TO SHARED-SAVINGS CALCULATIONS

Do shared-savings calculations involve risk adjustment?

Only about half of the studied models employed risk adjustment, with a few contemplating risk adjustment in the future. Those models that do employ risk adjustment use four different models: the Center for Medicare and Medicaid Services' (CMS) hierarchical condition categories methodology; the Prometheus payment methodology; or one of two leading commercial risk-adjustment software packages, the Johns Hopkins' adjusted clinical groups case-mix system and the Verisk Health Sightlines DxCG risk solutions product.

Models electing not to use risk adjustment were more likely to be medical home initiatives or believed that risk adjustment was not imperative because the shared-savings model involved comparing the provider's performance to its own past performance, with an assumption that the patient population risk burden would not vary much from year to year.

What in-kind or other supports do payers supply providers operating under shared-savings arrangements, and how are these treated in the calculation of savings?

Payers vary considerably in their approaches to supporting providers operating under shared-savings arrangements. In the vast majority of cases, support is provided at no cost to providers. Only two payers interviewed for this study reported they charged providers for support. The value of the support was never reported to be netted out of any savings.

The primary form of payer support is the provision of reports and data, including:

- claim files for provider manipulation and analysis; these are most commonly desired by large provider organizations with the resources to maintain a sophisticated internal analytic function and that are seeking an alternative to multiple independent reports from different payers;
- access to a payer database with software tools that provide standard reports and allow for customized inquiries;
- a suite of patient attribution, utilization, cost reports, made available most often through a payer's Web portal; and
- ad hoc analyses at the provider organization's request.

In several instances payers provide by consultation physicians, nurses, or other payer staff to providers on the interpretation and applied use of data and reports. Assistance and consultation in delivery system redesign and practice transformation is less common and takes the following forms:

- learning collaborative or primary care practice coaching, primarily in medical home initiatives;
- care management training, both practice-based and inpatient;
- roundtables and forums for provider organizations to exchanges ideas and best practice; and
- hospital admission and emergency department notification.

ACHIEVING ACCEPTABLE CONFIDENCE IN SAVINGS CALCULATIONS

What is the minimum size of a provider's panel of patients to participate in the shared-savings arrangement?

Shared-savings arrangements vary significantly in terms of the minimum number of patients for whom a provider must care. While some studied models set no patient population minimum, either because they purposely elected not to or, more often, because they

involve very large provider organizations only, minimum patient populations are often required to ensure that savings calculations can capture savings with some degree of confidence of accuracy. Payers can be reluctant to enter into a payment model in which they may make additional provider payments that are not "real,"—that is, they may be the result of random variation. This is especially true because shared-savings arrangements by definition pose no downside risk to the participating providers. While adjustment for high-cost outliers removes some degree of random variation in health care costs, it does not adjust for it all. Also, this high-cost outlier adjustment provides some protection to providers, but does not address the source of greatest concern to some payers—paying bonuses for random variation that produces low costs.

This issue is relevant for both ACO-like and medical home shared-savings arrangements, although sometimes more challenging for the latter because the participating provider entities have tended to be smaller.

For commercially insured populations, required minimum patient populations varied from 1,000 to 10,000. For Medicare patient populations (traditional Medicare and Medicare Advantage), the required minimum patient populations ranged from 333 to 5,000. The latter figure is the minimum proposed by CMS for the Medicare Shared Savings Program. In one case, the thresholds were defined for the total provider patient population and savings calculated for all participating payers for commercial, Medicare Advantage, and Medicaid managed care.

Shared-savings methodologies that are service-focused rather than population-focused, such as Prometheus Payment and the Medicare Acute Care Episode Demonstration also set minimum thresholds. In the latter case the threshold was set for providers to qualify for the demonstration.

The variation in approaches to setting minimum population sizes is a result of differences of opinion among actuaries and statisticians and differences in business strategy by payer executives in three key areas:

- the level of statistical certainty produced by different population sizes;
- the risk tolerance of payers relative to different levels of certainty and uncertainty; and
- the relative priorities set by a payer when considering goals relative to statistical delivery.

One interviewee observed, "The fundamental question is whether the main purpose of shared savings is to incentivize the practices to change or to accurately reward practices for their efforts." Another interviewee commented that at his health plan's minimum threshold there was still much practice cost volatility, and he knew that his actuaries would have preferred a much higher number than that which the insurer adopted. If he had done what the actuaries wanted, there would not be many groups with shared-savings arrangements.

Designers of shared-savings models face important trade-offs, especially if they want to apply shared-savings models to smaller provider entities or to provider entities with which a given payer may have coverage responsibility for a relatively small percentage of the provider's patients.

How else do payers protect themselves against paying for savings that may not be "real?"

In some instances, payers have taken an additional risk protection step beyond minimum patient population thresholds. This involves the payer retaining some percentage of initial savings before sharing any additional savings with the provider. In the CMS Physician Group Practice Demonstration, if savings were 2 percent or less of the value of the estimated budget, CMS would make no bonus payments. Practices would only begin to share savings above that level and then up to a maximum of 5 percent. This type of cap is a component that generally was not found in commercial payer models. In two other models the retained percentage before sharing savings was 2 percent; in a third model, it was 5 percent; and in a fourth model, the participants would not disclose the percentage.

For the Medicare Shared Savings Program, CMS proposes to set a minimum savings rate (MSR) that an ACO must exceed to share in savings. The MSR is defined by both the number of assigned beneficiaries and a CMS-chosen confidence interval. The percentage of savings that must be realized before any are shared with the provider are still far greater for smaller ACOs than for larger ACOs. For example, an ACO with 5,000 Medicare beneficiaries would need to save at least 3.9 percent before any savings would be shared, while an ACO with 60,000 Medicare beneficiaries would be required to save at least 2 percent before any savings were shared. This contrasts with the majority of commercial payer models that have no minimum savings rate or utilize a flat percentage.

CMS requires that the savings exceed the MSR before savings are shared, but it will then share savings after the first 2 percent. There are exceptional circumstances—not found in any of the other studied models—when the 2 percent requirement is waived.[3]

In some models there is purposely no payer-retained savings because the savings are calculated for a service, rather than for a population. In these cases the payment rate for a specific service was discounted up front so that the payer automatically sees some savings prospectively.

What strategies have been adopted for providers that fall below the minimum patient volume thresholds?

The shared-savings cases in this study typically followed one of three courses of action with regard to the involvement of smaller provider entities in shared-savings arrangements when minimum population thresholds were not met.

1. Most commonly, the payers would exclude from eligibility those providers whose patient population fell below the payer's established threshold, although in a few instances exceptions were made.
2. In some cases payers combined small-provider entities into a pool with other providers to meet the threshold. Should the pool of providers earn savings, the savings are then be allocated across those providers that composed the group.
3. In a couple of instances, pooling was done for all participating providers.

Providers tend to argue against pooling or aggregating, as it results in a perceived loss of control and motivation. Some argue that pooling of all participating providers so dramatically reduces control that it is inconsistent with common understanding of shared savings. Providers appear to only support pooling if it is done across entities that have a preexisting contractual or organizational relationship.

In instances when pooling occurs, there are questions about how it is structured. Options include pooling providers by geographic proximity, organizational type, providers' primary specialty (for medical homes), patient mix, and baseline performance.

CALCULATING SAVINGS

How does the model determine if savings were achieved?

A basic question for any shared-savings model is the method for determining whether the provider's efforts achieved any savings. Savings are typically assessed for a 12-month measurement period. Models typically assess savings in two ways:

Comparison of provider-associated cost to a budget or target. Under this arrangement, the payer considers the past costs associated with the provision of care to the provider-attributed patient population and projects forward future costs. Such forecasting may take into account projected general medical trends, changes in benefit plan design, and planned cost containment strategies to be implemented by the payer. The cost budget can be subject to negotiation, with one payer comparing the process to a rugby match.

Approximately two-thirds of the studied models use a budget or target approach. In at least one instance the target was informed by looking at best

practice in the region and using those data, in part, to set the target.

The proposed Medicare Shared Savings Program uses a target or benchmark approach. As stated in CMS materials, "CMS would . . . develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings . . . . The benchmark is an estimate of what the total Medicare fee-for-service Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO."[4] CMS proposes setting its benchmark based on claims data from the previous three years for beneficiaries who would have been assigned to the ACO, with the most recent years weighted most heavily and adjustments made to account for the increase in national Medicare fee-for-services expenditures.

Comparison to a control group. In some cases the rate of change in the PMPM costs of patients attributed to a provider are compared with those of either a select comparison group or to the payer's full regional provider network (otherwise known as "book of business"), with the provider included or excluded from the book-of-business calculation. If the provider's trend rate falls below that of the control group, the difference in trend rates is used to calculate the amount of the savings. In some cases the control group is negotiated and in other cases it is defined by the payer.

There are some additional variations with regard to the implementation of these two approaches:

- Savings can be calculated by comparing the PMPM costs of patients attributed to a provider to the prior year experience, without any comparison to a control group.
- Both the budget and the control group trend comparison can be calculated using a subset of services rather than something approximating or equally total medical expense. For example, the model can consider only expenses related to inpatient hospital use and emergency department service use, since these two areas are usually considered to be two primary sources of savings. It can also consider trend rates for only patients with chronic conditions for whom cost savings opportunities may be greatest.

Those who support the budget approach say that its strength is allowing providers to know what needs to be achieved. Its detractors note the perilous nature of forecasting medical trends for purposes of establishing a budget, noting the impact of unanticipated events such as flu epidemics and sudden changes in the economy.

Those who support the control group approach note that it protects against external factors that significantly drive medical expense trends and uses real, rather than projected, figures to assess savings. Its detractors observe that control groups are not always easily defined (and will become less so as payment reform expands) and that the computations to ensure true comparability—including possible adjustments for case mix, changes in product mix, provider contract rates, and geographic factors—can be complex.

DISTRIBUTING SAVINGS

For what percentage of savings are providers eligible?

Shared-savings models take many different approaches toward allocating savings between the provider and the payer. For multiprovider entities, there are further metrics for allocation of savings among the providers.

The most common distribution of provider and payer net savings is 50 percent to the provider and 50 percent to the payer.[5] As discussed further below, in many cases the provider percentage is contingent on acceptable or strong performance on a set of measures. While a 50/50 split arrangement is most common, there are many other approaches, including:

- the provider earning more than 50 percent, with percentages rising to 65 percent and even 80 percent;
- the precise provider share can be determined by the provider's nonfinancial performance using a set of measures, with the distribution

of savings scaled from 0, 20 percent, or 40 percent.

- providers can earn a flat percentage, but the total dollars shared can be capped; for example, in one arrangement the payer shares savings up to 6 percent after an initial 2 percent payer retention. With a 50/50 split, the most the provider can earn is 3 percent of the budget amount; and
- in the Prometheus Payment model, the payer takes its savings out of the bundled payment and then the provider earns whatever savings it can generate from the discounted payment.

As is the case with other shared saving design elements, the percentage of savings for which each party is eligible is often subject to negotiation.

Are the size of provider savings payments contingent on considerations other than savings achievement?

Almost every observed shared-savings model uses performance on access, patient experience, quality, and/or service utilization to determine the percentage of savings the provider will receive. The measures most often tend to address preventive and chronic care services, and for ACO-like entities, acute care services.

Gates and ladders. In some models, performance measures serve to define a minimum qualification or "gate." If the provider meets the minimum performance requirement, it is entitled to a fixed percentage of savings. Other models are more complex. They define a gate, but also specify that the provider can increase its savings beyond that amount by performing better relative to a performance measurement set and moving up a "ladder." In such instances, the percentage of savings eligible for meeting the minimum standards—that is, passing through the gate—is typically less than 50 percent.

The proposed Medicare Shared-Savings model may be the most complex example of this latter approach, with 65 measures spread over five performance domains, and providers expelled from the program for not meeting minimum performance standards for one domain for two years. Each measure within a domain is worth a maximum of two points and a minimum of zero points, with points assigned based on performance relative to national Medicare fee-for-service and Medicare Advantage percentiles. An ACO would get a single score for the domain based on the percentage of total points achieved. The average of the five domain scores would be the overall score, which would determine the percentage of the shared savings an ACO receives.[6]

The Medicare Shared Savings Program design does not include, although it is common in other models, the use of utilization measures. These measures typically assess the extent to which the provider is reducing preventable acute care service use including inpatient readmissions, potentially avoidable inpatient admissions, and potentially avoidable emergency department visits.

The use of utilization measures has been a topic of debate. The measures can be viewed as both quality measures but also as indicators of efficiency and cost savings. Some have argued that their inclusion represents a redundant incentive because, even without these measures, the provider will seek to achieve savings through reduced need for and delivery of these services. Still, some payers insist on their inclusion because of the perceived imperative for the payers to reduce costs associated with utilization of these services.

In one model, quality measures were employed as the qualifying gate, while utilization measures determined the percentage of savings earned above the gate. In other cases, quality, utilization, and other measures are not differentiated for purposes of evaluating performance and determining the percentage of distributed savings.

Overall, preventive care, chronic illness care (process measures and interim outcome 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.

Benchmarks vs. improvement. Shared-savings models that use performance measures to determine

provider savings allocation tend to use three basic approaches. The first involves scoring provider performance relative to a benchmark. Examples include regional Healthcare Effectiveness Data and Information Set (HEDIS) percentiles and payer-defined percentiles, as in the CMS Shared Savings Program. As providers meet or exceed higher benchmarks for each measure or composite measure, they earn more points, which translate into a larger share of savings.

The second approach assesses the extent to which provider performance has improved compared with the prior year. Some models require the improvement to be statistically significant while others do not.

The third approach is to consider both performance toward benchmarks and performance improvement. One such example is to require annual improvement until such time that the provider reaches a high external benchmark, at which point the provider must only maintain performance at or above the benchmark year-over-year.

As with most every element of shared-savings model design, there are many variations in the application of the above approaches, including the following:

- the percentage of savings that is contingent on selected performance measures increases over a five-year phase-in period;
- either reporting measures or maintaining performance is required in the first year, while performance improvement is required in the years that follow;
- quality cannot be a consideration in a shared-savings distribution and the payer can operate a separate but parallel quality incentive pool; and
- quality scores can be combined into a composite measure for assessment purposes to respond to the problem of small observation counts for small provider entities.

THE FUTURE FOR SHARED-SAVINGS MODELS

Are shared-savings methodologies considered long-term or transitional payment strategies?

Many provider and payer participants view shared-savings payment methodologies as transitional, but with an undefined timeframe. Most providers and payers view their recent forays into shared savings as a learning experience and do not presume to know when they will want or be ready to transition to a risk-based payment arrangement with a combination of downside risk and greater upside risk. This approach stands in contrast with the proposed CMS Shared Savings Program, which requires that ACOs transition to a reciprocal upside and downside shared-risk model after two years.

A significant number of shared-savings participants see the model as a long-term strategy, albeit with adjustments over time. At least one payer felt that payment arrangements with downside provider risk would never be viable for smaller provider entities.

CRITICAL ISSUES IN SHARED-SAVINGS DESIGN AND IMPLEMENTATION

This analysis has revealed a considerable amount of activity in the design and implementation of shared-savings payment models. It seems likely that additional outreach efforts would have yielded many more varied examples.

The current flurry of activity is sparking creativity and the opportunity to try different approaches. This natural experimentation will facilitate learning, as not all efforts are likely to be equally effective. The trade-off for this experimentation will be the variety of models and performance measures that providers will face and the difficulty for providers trying to respond to disparate incentives.

It is difficult to know what will be the determining success factors for shared-savings payment models, but there are a few critical issues to address and resolve.

Determining if Savings Have Been Achieved

Very few interviewees identified this issue as central, but it appears it will be an increasing source of conflict. For those who spoke about it, the topic was the basis for extensive research, analysis, and negotiation. Unless shared-savings programs are implemented only with the very largest of provider organizations—and this scenario seems unlikely—payers and providers must resolve the tension between statistical certainty that savings have been realized and providing a meaningful and attainable incentive for providers to generate savings.

Ensuring Providers Succeed

Payment reform provides an incentive for transformation of care delivery, but it does not ensure it. While most interviewed providers recognized this, the payers did not always convey the same understanding. In order to succeed, providers will need certain tools.

Timely, trended performance data with targets and benchmarks, and the ability to manipulate data. Most payers are making some data available, but providers need more information. In addition, the provided data are neither consistent nor integrated across payers, except in cases where payers are sending non-Medicare claims files to providers who do their own claims aggregation. Medicare is particularly challenged to provide this support.

Knowledge and implementation of systems and processes to deliver better care more efficiently. While some interviewed payers expressed an assumption that large organizations would be able to "figure it out," there are reasons to doubt that providers will always know how to fundamentally transform their businesses. The largest provider organizations have invested heavily in consulting services, process redesign, and infrastructure development, but not all provider organizations have the capacity to do so. Smaller provider organizations and those in poor financial health may have great difficulty responding to the incentive presented by the opportunity to share savings.[7]

Aligning Measurement

While some degree of variation across payers may be of value in the near term, competing sets of performance measures in shared-savings methodologies could eventually harm the effectiveness of the payment models, since providers will find it difficult to focus. There may be opportunities for regional coalitions to identify a common framework with which nonfederal payers might align.

Refining the Shared-Savings Model

National expectations are high that payment and delivery system reform, simultaneously being advanced by both public and private sector payers, will finally slow the inexorable march of health care cost growth. The scope and complexity of the challenge make it unlikely that the great expectations of today will be immediately realized tomorrow. It will be necessary to learn within and across payer and provider organizations from initial successes and failures and to maintain a resolve to persistently refine the payment model to maximize effectiveness.

HOW THIS STUDY WAS CONDUCTED

This issue brief is one of several projects funded by The Commonwealth Fund to document alternative payment models. Most closely related is a project being conducted in parallel by Catalyst for Payment Reform to identify and document ACO shared-risk programs in the public and private sectors. The two project teams have collaborated in their respective work to ensure as comprehensive a list of shared-savings and shared-risk models as possible.

Bailit Health Purchasing conducted 32 telephone interviews with payer and provider organizations and state agency agencies that indicated they were involved in 27 independent past, current, and planned shared-savings payment arrangements. Interviews were performed using a structured instrument. In addition, Bailit considered the Notice of Proposed Rule-Making for the Medicare Shared Savings Program, released on March 31, 2011, by the Centers for Medicare and Medicaid Services (CMS), as an additional shared-savings model for comparative analytical purposes.

The assessed shared-savings programs were primarily applied in primary care practice medical home programs and in ACO-like payment arrangements involving a more broadly defined provider organization such as a multispecialty group practice, integrated delivery system, physician–hospital organization, or independent practice association. While the medical home shared-savings programs also involved the payment of supplemental payments (typically per member per month), the ACO-like shared-savings programs did not.

Approximately one-third of the arrangements were formed through medical home or medical home-like programs. Because the medical home and ACO-like shared-savings models did not differ considerably in construction beyond medical home programs providing supplemental per member per month payments, the findings are reported in an integrated fashion.

With the notable exception of the Medicare Physician Group Practice demonstration and experience in California, most of the case examples have been of relatively short duration.[8] Approximately two-thirds of the arrangements had 2010 or 2011 start dates. In addition, only the Physician Group Practice demonstration had been formally evaluated for effectiveness.[9]

Finally, it is worth noting that not all self-described shared-savings models meet the definition provided above. In one instance an interviewee revealed that an insurer operated a predefined bonus pool that distributed bonus payments based on provider success in reducing costs. In another instance, the extent to which a provider generated savings influenced the degree to which the provider's fees would be increased in the following year.

Notes

1 D. McCarthy, R. Nuzum, S. Mika, J. Wrenn, and M. Wakefield, *The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation* (New York: The Commonwealth Fund, May 2008); and M. Bailit, *Payment Rate Brief* (Washington, D.C.: Patient-Centered Medical Home Initiative, March 2011).

2 By excluding acute-care services due to accidents over which the provider may have little perceived influence, at least one initiative believed it could reduce the amount of random variation in medical expenses. It is worth noting that Medicaid payers view accidents as potentially preventable, since they may be attributed to misuse of alcohol or other substances.

3 The circumstances are as follows: 1) all ACO participants are physicians or physician groups; 2) 75 percent or more of the ACO's assigned beneficiaries reside in counties outside a metropolitan statistical area; 3) 50 percent or more of the ACO's assigned beneficiaries were assigned on the basis of services received from Method II Critical Access Hospitals; and 4) at least 50 percent of the ACO's assigned beneficiaries had at least one encounter with a participating rural health clinic or federally qualified health center.

4 Centers for Medicare and Medicaid Services, *What Providers Need to Know: Accountable Care Organizations* (Washington, D.C.: U.S. Department of Health and Human Services, April 2011), http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf.

5 In arrangements where the payer has provided prospective payments, as is common in medical home models, those payments are typically netted out of any savings.

6 M. A. Zezza, *Proposed Rules for Accountable Care Organizations Participating in the Medicare Shared Savings Program: What Do They Say?* (New York: The Commonwealth Fund, April 2011).

7 Research suggests that pay-for-performance has proven less effective with hospitals in poor financial health than for those in a strong financial condition. See R. M. Werner, J. T. Kolstad, E. A. Stuart et al., "The Effect of Pay-for-Performance in Hospitals: Lessons for Quality Improvement," *Health Affairs,* April 2011 30(4):690–98.

8 This demonstration was a model for the Medicare Shared Savings Program. Its design differed from the proposed draft Shared Savings Program in several ways. A few examples include 1) the demonstration's focus on very large practice organizations, 2) the demonstration's exclusive use of shared savings (and not shared risk), and 3) the use of an external control group to assess savings achievement as opposed to calculating expected spending based on the previous three years of historical expenditures for the same assigned patients.

9 The evaluation concluded, "The improvement in the quality measure processes and reporting in the first two years of the demonstration suggest that access has been improved while providing high quality care. The effect of the demonstration on promoting expenditure savings is less certain." See K. Sebelius, *Report to Congress: Physician Group Practice Demonstration Evaluation Report* (Washington, D.C.: U.S. Department of Health and Human Services, 2009), http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_RTC_Sept.pdf.

Appendix. Interviewed Organizations

Organization	Organizational Type
Advantra Total Care (KS)	Provider
AdvocateCare (IL)	Provider
Anne Arundel Health Systems (MD)	Provider
Anthem Blue Cross (CA)	Payer
Baptist Health System (TX)	Provider
Billings Clinic (MT)	Provider
Blue Cross Blue Shield of Illinois	Payer
Blue Cross Blue Shield of Minnesota*	Payer
Blue Cross Blue Shield of Tennessee	Payer
Blue Shield of California	Payer
Capital Blue Cross (PA)	Payer
CareFirst (MD)	Payer
Centers for Medicare and Medicaid Services (Medicare Physician Group Practice Demonstration)	Payer
Centers for Medicare and Medicaid Services (MMA 646 Medicare Health Care Quality Demonstration programs in Indiana and North Carolina)	Payer
Everett Clinic (WA)	Provider
Fairview Health System (MN)	Provider
Geisinger Health System (PA)	Provider
Harvard Pilgrim (MA)	Payer
Health Partners (MN)	Provider
Independence Blue Cross (PA)	Payer
Maryland Health Care Commission	State
Massachusetts Executive Office of Health and Human Services	State
Medica (MN)	Payer
Northwest Physicians Network (WA)	Provider
Norton Healthcare (KY)	Provider
Pennsylvania Governor's Office of Health Care Reform	State
Prometheus Payment	Payment organization
Regence BlueShield of Washington	Payer
Tucson Medical Center (AZ)	Provider
UW Medicine Neighborhood Clinics (WA)	Provider
Washington Health Care Authority	State
WellStar Health System (GA)	Provider

Note: In a few instances a consultant to a state was interviewed in lieu of state personnel.
* Interview performed by Booz Allen and results shared with Bailit Health Purchasing, LLC.

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