The Design and Application of Shared Savings Programs: Lessons from Early Adopters

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Synopsis

Enabling health care providers to share in the savings they generate from the delivery of more efficient, higher-quality care is a promising way to achieve the goals of health reform. Reaching agreement on the methods used to calculate and distribute such savings, however, has been a challenge for payers and providers alike. By following a set of design principles, payers and providers may be able to sidestep some of the pitfalls encountered by early adopters of this payment approach.

The Issue

Shared-savings programs that reward physicians and other health care providers for meeting cost and quality targets, but do not penalize them for missing targets, can be a first step in helping providers manage discrete patient populations. While these shared-savings arrangements present no downside risk to providers, they can be difficult to negotiate. Conflicts often arise from concerns over the equitable calculation and distribution of savings. As part of a Commonwealth Fund-supported study, researchers conducted a review of past, current, and planned shared-savings arrangements to identify common elements and challenges.

Key Findings

- In a nationwide sample of shared-savings arrangements, the researchers found that each one has processes in place to: 1) calculate savings, 2) distribute savings, and 3) measure performance and provide support for transforming practices into fully functioning accountable care organizations (ACOs) or patient-centered medical homes.
• Methods for measuring and distributing savings are designed to ensure that providers are not
rewarded for savings that could be attributed to random variation in health care costs. The authors
found wide variation in how each program attributes patients to practices, selects savings benchmarks,
sets minimum thresholds that providers need to reach before they are eligible for a savings
distribution, establishes control groups, sets minimum panel sizes, and allows exclusions.

• To counter the perception that the payment models are designed solely to reduce costs, virtually all of
the shared-savings contracts included eligibility criteria based on measures of access, quality, or
patient experience.

• To help payers and providers find common ground, the authors proposed a number of design
principles for shared-savings programs. These include recommendations to: 1) group together similar
small practices to enhance stability of the estimates; 2) apply risk adjustment where appropriate; 3) use
sliding scales to distribute savings; 4) encourage multipayer initiatives that pool data and align
measures and incentives; and 5) ensure provider buy-in by making the process transparent.

Addressing the Problem
Physicians may require additional assistance to succeed in reducing spending and improving quality of
care. For example, they may need data to help them understand the range of services their patients
receive inside and outside the practice as well as data to identify high-risk patients, assess potential
overuse, and track quality measures. Learning collaboratives or practice coaching may also be necessary
to aid the transformation process.

About the Study
The authors relied on business contacts, publicly available data, and Internet searches to develop a
sample of payer and provider organizations and state and private agencies involved in past, current, and
planned shared-savings arrangements. Twenty-seven organizations participated, and 32 interviews were
conducted. The majority were sponsored by commercial payers. One-fourth involved medical home or
medical home–like programs.

The Bottom Line
Shared-savings arrangements will likely play a key role in health system reform, but they can be complex
and difficult to negotiate. Understanding the advantages and pitfalls of different program design features is
critical to reducing costs and improving the quality of patient care.

Citation
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*This summary was prepared by Sarah Klein.*