



SHARED-SAVINGS PAYMENT ARRANGEMENTS IN HEALTH CARE SIX CASE STUDIES

Michael Bailit, Christine Hughes, Megan Burns,
and David H. Freedman

Bailit Health Purchasing, LLC

AUGUST 2012

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Abstract: Driven by widespread interest in improving health care quality and reducing costs and by the Affordable Care Act’s “accountable care” provisions, shared-savings programs are gaining traction as an alternative approach to paying health care providers. Providers receive a share of the savings they achieve by reducing the growth in costs for delivering care to a defined patient population. This report presents six case studies of pilot shared-savings programs across the country. The cases reveal program variation in the patient populations subject to shared-savings approaches, the health care services covered, the determination of cost savings and payouts to providers, the use of performance targets, and performance measurement. Early results from the pilot programs also vary. Exploring differences in shared-savings approaches, and the outcomes they achieve, will be essential to determining whether they work, how to improve them, and whether and how to diffuse them.

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EXECUTIVE SUMMARY

One of the most talked-about new ideas in health care is rewarding providers for reducing medical spending by giving them a share of the net cost savings. Driven by an interest in seeing medical homes and other providers shift to some form of performance-based payment, as well as by the Affordable Care Act's push for "accountable care," shared-savings approaches are currently being tested by numerous payer and provider organizations across the United States.

Given uncertainties regarding an ideal shared-savings approach and how best to implement it, we examined six shared-savings pilot initiatives. For each case study, we interviewed leaders at payer and provider organizations and state agencies about their attempts to design and implement shared-savings programs.

These pilot programs, we found, vary considerably on several dimensions (Exhibit ES-1). These include the patient populations subject to shared-savings arrangements, the health care services those arrangements cover, how payers determine cost savings and payouts to providers, whether the model incorporates performance targets, and how it measures performance. These pilot projects also vary in their early impact on health care costs and payouts to providers. For example:

- One initiative measures cost savings related to preventable complications from specific procedures, and is on track to make a substantial payout to providers.
- A second initiative does not require providers to serve a minimum number of patients to participate, uses a control group and 21 quality measures to determine payouts to participating providers, but has not yet demonstrated cost savings.

- A third initiative requires providers to serve a minimum number of patients to participate, uses the average per-patient cost of health care in a metropolitan area as a benchmark, and has paid out up to 75 percent of shared savings to a provider.

Despite these variations, the case studies reveal consistent themes regarding shared-savings approaches to payment for health care services. These common elements include a willingness among most payers to absorb many of the costs entailed in setting up and sharing tools for measuring health care performance and cost savings. Overall themes also include a belief that shared-saving programs must evolve to include shared risk, and a conviction that even when pilot programs fail to achieve savings, they are moving in the right direction.

We do not yet know whether this approach is a long-term strategy for promoting better health care while lowering costs, or a transitional strategy to some other model, such as global payments for which the provider also assumes risk if spending is higher than a budget target. Exploring the organizational and environmental differences in how participants pursue shared-savings approaches, and the outcomes they achieve, will be key to determining whether they work, how to improve them, and whether and how to diffuse them.

EXHIBIT ES-1. KEY DESIGN FEATURES OF SHARED-SAVINGS PILOT PROGRAMS

	MARYLAND MULTI-PAYER PATIENT-CENTERED MEDICAL HOME PROGRAM (MMPP)	MEDICA AND FAIRVIEW HEALTH SERVICES	HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE (PROMETHEUS PAYMENT)
Patients, Services, and Payments			
<i>Patient population(s)</i>	Commercial; Medicaid managed care	Commercial	Commercial; Medicare Advantage
<i>Methodology for attributing patients to provider groups</i>	12-month claims history Most frequently visited provider (most recent if tied)	Johns Hopkins ACG software and a 12-month look-back to determine site of at least 50% primary care spending	Not required
<i>Type of payments</i>	Semiannual lump-sum payment Incentive payment based on cost savings	Per-patient, per-month management fee for disease care coordinator Shared savings based on comparison with a control group	Shared savings for reducing potentially avoidable complications (PAC) associated with treating a chronic condition
Special Adjustments to Shared-Savings Calculations			
<i>Adjustments for patient risk</i>	None at the time	ACG grouper High-cost claims truncated at \$250,000 to \$500,000, depending on contract	Stop-loss provision High-cost claims (episodes exceeding two standard deviations) truncated
<i>Supports for providers</i>	With state funding, University of Maryland and Johns Hopkins School of Medicine provide training on care coordination and evidence-based medicine, etc.	Data support and analysis Some care management and health coaching may be available	Tools and services to help payers and providers use the Prometheus Payment software and share best practices
Inputs for Calculating Savings			
<i>Minimum number of patients per practice group</i>	None	15,000–20,000 member-months	Minimum number of patients with certain conditions and treatments
<i>Retention of initial percent of savings by payer</i>	None	None	Payer takes upfront share (discounted PAC allowance)
Method for Calculating Savings			
<i>Comparison with:</i>	External benchmark (TBD)	Control group	Budget
Method for Distributing Savings			
<i>Percent cost savings eligible to providers</i>	30%–50%, depending on performance	Up to 75%, split among providers: one-third to hospital; one-third to care management; one-third to physician groups	Varies by payer, but PAC allowances must be at least 50% of budget
<i>Performance targets</i>	21 quality measures; and reductions in use of high-cost services, such as emergency department and hospital readmissions	Minimum quality gate, then confidential algorithm	Must achieve net 6% reduction in cost of PAC to receive payout Quality scorecard available for use

EXHIBIT ES-1. KEY DESIGN FEATURES OF SHARED-SAVINGS PILOT PROGRAMS (CONTINUED)

BLUE CROSS BLUE SHIELD OF ILLINOIS AND ADVOCATE HEALTH CARE	HEALTHPARTNERS	HARVARD PILGRIM HEALTH CARE
Patients, Services, and Payments		
Commercial	Commercial; Medicaid (two of the latter providers opted to participate, but with separate calculations)	Commercial
Jointly developed confidential methodology with a two-year look-back and tie-breaking algorithm	Retrospectively attributed using internally developed algorithm	Prospectively assigned using internally developed algorithm
Shared savings based on comparison with a control group	Shared savings based on comparison with a negotiated target	Shared savings compared with a budget
Special Adjustments to Shared-Savings Calculations		
DxCG software	ACG software	DxCG software
Services excluded: transplantation	High-cost claims truncated (amount confidential)	High-cost claims (>\$50,000) truncated Services excluded: transplantation, behavioral health, and out-of-area services
Reports, data feeds, and software tools to download data directly into electronic medical records systems	Detailed analysis of performance, including cost and use of services, location of services, medical conditions, and specialty	Basic reporting tools for tracking performance; access to best-practice examples
Analytical support for targeted high-risk members	Some grant money to help build needed infrastructure	Care management tools, hospital utilization review, and in-depth reports available for extra fee
Inputs for Calculating Savings		
None, but only provider groups with >100,000 members are participating	None, but only large provider groups are now participating	3,000–5,000 patients
Yes (amount confidential)	None	2%
Method for Calculating Savings		
Control group: nonparticipating provider network	Jointly negotiated target	Budget
Method for Distributing Savings		
Up to 50%	50% (commercial and Medicaid savings calculated separately)	50/50 split of savings up to 6% of total budget, after plan takes 2% (3% max for provider group)
Minimum quality gate includes 12 measures; Year 1: maintain performance Years 2 & 3: negotiated targets	None	No, but separate pay-for-performance program

SHARED-SAVINGS PAYMENT ARRANGEMENTS IN HEALTH CARE: SIX CASE STUDIES

Introduction

One of the most talked-about new ideas in health care is rewarding providers for reducing medical spending by giving them a share of net cost savings. Driven by widespread interest in seeing medical homes and other providers shift to some form of performance-based payment, as well as by the Affordable Care Act's push for "accountable care," and shared-savings approaches involving numerous payer and provider organizations are emerging. The structure and performance of these pilot projects can shed light on what to expect from the Medicare Shared Savings Program for accountable care organizations and other initiatives—and on how payers and providers can engage in these efforts.

In a previous Commonwealth Fund policy brief, we summarized 27 examples of shared-savings initiatives.¹ We found wide variation in critical details in how participants implemented such initiatives. These variations included how payers assign patients to providers to evaluate cost savings, how payers adjust the risk profiles of pools of patients based on their health care needs, and how payers actually calculate and distribute savings.

That earlier study also made clear that payers and providers must resolve a number of key challenges if shared-savings plans are to realize their promise. These include ensuring that identified savings do not merely reflect random variations in health care costs—which is particularly important if providers incur no explicit penalty if they fail to achieve savings. Other key challenges include selecting measures that focus providers on improving performance as well as reducing costs, and equipping them with the data and tools they need to improve their effectiveness and efficiency.

Given these uncertainties regarding an ideal shared-savings approach and how best to implement it, we chose six initiatives from among the many we cited in that earlier issue brief to examine more closely. For these case studies, we interviewed leaders at payer and provider organizations and state agencies regarding their attempts to design and implement shared-savings programs.

We found that these pilot programs vary considerably on several dimensions (see [Exhibit ES-1](#)). These include the patient populations subject to shared-savings arrangements, the health care services those arrangements cover, how payers determine cost savings and payouts to providers, whether the model incorporates performance targets, and how it measures performance.

On one idea, however, we found complete agreement: These programs have the potential to spur essential changes in the delivery and cost of patient care, given an existing system widely recognized as untenable.

¹ M.H. Bailit and C. Hughes, *Key Design Elements of Shared-Savings Payment Arrangements* (New York: The Commonwealth Fund, Aug. 2011).

MARYLAND MULTI-PAYER PATIENT-CENTERED MEDICAL HOME PROGRAM

The Maryland Health Care Commission launched its Multi-Payer Patient-Centered Medical Home Program (MMPP) in April 2011. This three-year pilot aims to provide 200,000 patients with access to high-quality, patient-centered primary care. To support that goal, the MMPP is providing training and support to encourage 200 primary care providers working at 50 practices to coordinate care, use evidence-based medicine, improve the quality and safety of care, and strengthen communication with patients.

The Maryland legislature required the five largest health plans in the state—CareFirst, Aetna, Cigna, UnitedHealthcare, and Coventry—to participate in the MMPP.² Medicaid managed care plans have also joined the pilot program. These private and public payers have agreed to award participating practices two extra payments beyond the usual fee-for-service or capitation payments.

Why Shared Savings?

The commission did not expect that providing funding for better care management alone would reduce costs. The commission is therefore pursuing a shared-savings model to promote and support the concept of a medical home, including among self-insured employers.

Shared-Savings Methodology

Patient Population: Minimum Size and Attribution

A practice does not need to serve a minimum number of patients to qualify for the incentive payment. Participating practices average about 1,850 patients. The Maryland Health Care Commission assigned patients to a given practice at the outset of the program, and reattributes patients every six months.

To do this, the commission uses a two-step process based on 24 months of claims information from all payers. First, staff members identify the practice each patient has visited most often in the past 12 months, and attributes the patient to that practice. In

the event of a tie, the practice that the patient visited most recently is deemed responsible for the patient. For patients who have no claims history for the past 12 months, staff members use the prior 12 months to identify a practice that is responsible for those patients.

Determining and Distributing Savings

The first of the two extra payments to providers is a semiannual lump sum designed to cover the extra cost of high-value efforts that historically have been unreimbursed. These include coordinating and managing care and using information systems. Provider groups are automatically eligible for this payment if they fulfill requirements for participating in the MMPP, including reporting their scores on specific measures of health care quality.

The payments are based on projected cost savings from improving the quality of care, especially for patients with chronic health conditions. The MMPP uses a set of budgeting and evaluation tools made available by the Health Care Incentives Improvement Institute to estimate potential savings from avoiding complications for seven common chronic illnesses.

The commission bases these payments on expected savings rather than the actual investments needed to improve care for two reasons. First, payers and providers alike were unwilling to invest “new money” into improving the health care system. Second, the commission expects costs to vary depending on which systems a medical practice already has in place, and how efficiently it transforms itself into a patient-centered medical home.

This payment varies with the size of a practice’s patient population, whether it has achieved certification from the National Committee for Quality Assurance (NCQA), and the level of that certification.³ Payments also vary depending on whether the payer is a commercial health plan or Medicaid.

² The state excluded Kaiser from the mandate because of the nature of its affiliated delivery system.

³ Practices must achieve NCQA recognition as a Level 1 patient-centered medical home within the first six months of the program, and Level 2 recognition within 18 months. For more information on NCQA standards, see <https://inetshop01.pub.ncqa.org/publications/product.asp?dept%5Fid=2&pf%5Fid=3004%2D301%2D11>.

The second extra payment to providers, known as an incentive payment, rewards them for controlling health care costs during a given year, as well as for meeting certain performance targets. The share of cost savings that a practice may retain rises with its performance.

An incentive payment is available only to practices that reduce medical expenses compared with practices that are not participating in the pilot program. The commission uses the Maryland all-payer claims database to calculate cost savings. The commission used 2009 and 2010 data to perform test calculations in May 2012 and reported results to participating primary care practices. The first shared-savings payments will be made in late 2012, based on data for 2010 and 2011.

The MMPP relies on two sets of performance criteria to distribute incentive payments to practices. The first, Group One, consists of 21 measures of health care quality. In the first two years, practices must simply report their performance on some of these measures. In the third year, practices must meet quality thresholds (e.g., HbA1c (blood sugar) controlled to a level of less than 8 percent).

The second set of criteria, Group Two, measures reductions in the use of high-cost health care services, such as emergency department visits and admissions for ambulatory care-sensitive conditions. The latter standards apply only in the second and third years. Practices must improve their performance each year to receive incentive payments based on these criteria.

Both Group One and Group Two criteria are tiered, so practices receive different percentages of cost savings based on their performance. For example, practices in the lowest tier are eligible for a 30 percent share of savings, while those in the highest tier are eligible for 50 percent. Health plans and self-funded employers keep the rest of the cost savings.

Adjusting for Patient Risk

The MMPP does not have a formal process for adjusting the results reported by each practice based on the risk profile of its patient population. However, the commission plans to decide whether to pursue some form of risk adjustment after gaining experience with attributing patients to practices and awarding incentive payments.

The shared-savings method adopted by the commission controls for risk by calculating costs only for patients attributed to the primary care practice in both the baseline and performance years. There is no additional risk adjustment. However, the commission does adjust patient-cost calculations to mitigate the impact of random events, such as by excluding catastrophic cases.

Technical Assistance

The state is funding the University of Maryland and the Johns Hopkins School of Medicine to provide technical support and training to help practices participating in the MMPP implement the patient-centered medical home.

Maryland Health Care Commission's Experience with the Shared-Savings Model

The commission began distributing MMPP payments in July 2011. It has not yet evaluated the results of the shared-savings model.

MEDICA AND FAIRVIEW HEALTH SERVICES

Medica provides health coverage to 1.6 million members, including individuals as well as through employers, third-party administrators, and government programs in Minnesota and select counties in Wisconsin, North Dakota, and South Dakota. More than 96 percent of providers in Minnesota participate in Medica's network. Some 600 primary care providers representing about 20 clinics in Medica's network are participating in its shared-savings arrangement.

The largest of these is Fairview Health Services. Fairview is a nonprofit health care system based in Minneapolis with more than 40 primary care clinics, a wide range of specialty services, inpatient care, home care, and senior services. The integrated medical practice includes more than 700 Fairview-employed physicians and more than 700 physicians affiliated through University of Minnesota Physicians, the multispecialty practice of the university's medical school faculty.

Fairview began a shared-savings arrangement with Medica in June 2009, with 300 of its primary care providers participating. Fairview signed shared-savings agreements with two other commercial payers, Blue Cross and Blue Shield of Minnesota and HealthPartners, in January 2011.

Medica added five other provider groups in 2010. More than 70 percent of Medica's members are now covered under some type of shared-savings model.

Why Shared Savings?

Medica chose shared savings because employers could not afford escalating health insurance costs. Furthermore, in Minnesota's not-for-profit insurer environment—where provider payments account for 90 percent of costs—shared savings was a promising strategy to control these costs.

Medica chose Fairview as a partner for several reasons. It was not only the largest practice in the insurer's network, but appeared to be the most ready to participate in a shared-savings approach, having implemented a chronic care management model for one year before the pilot began. Fairview's providers are also in

Minneapolis/St. Paul, where most of Medica's members are also concentrated.

Medica and Fairview developed their approach to shared savings jointly. Both see the move away from fee-for-service payment as permanent, but acknowledge that this model is transitional, expecting it to last two to three years. What the next model will be is unclear, but they have discussed relying on a comprehensive or global payment per patient.⁴

Shared-Savings Methodology

Patient Population: Attribution and Minimum Size

Medica's shared-savings pilot covers 800,000 to 900,000 individuals. These include members enrolled in fully insured and self-insured preferred provider organizations (PPOs), as well as small numbers of members enrolled in commercially insured health maintenance organizations (HMOs).

Medica uses the John Hopkins Ambulatory Care Groups (ACG) software to attribute members to participating practices. This software uses a 12-month look-back to identify the medical practice where each patient has incurred 50 percent or more of his or her primary care dollars.

Medica requires participating providers to have a minimum of 15,000 to 20,000 member-months, or 1,250 to 1,667 patients (the range allows for changes in a practice's patient population). Medica used actuarial testing to develop this requirement, which is designed to ensure that the plan can gather enough accurate data to calculate cost savings.

Fairview wanted to include low-volume providers in the pilot. According to a Fairview interviewee, "It was very clear that the small practices add real value to the system; some are very efficient, so excluding them is not smart." Fairview therefore uses its own methodology to pool providers so they can participate in the pilot.

⁴ CMS accepted Fairview as one of 32 Pioneer accountable care organizations, effective January 1, 2012. Under this program, Fairview will contract with CMS with the possibility of both shared savings and shared losses.

Determining and Distributing Savings

Medica and Fairview continue to rely on fee-for-service claims to award base payments to provider groups. They also award a per-member, per-month (PMPM) management fee to participating practices, which are expected to hire a disease care coordinator. Medica does not net out any portion of these payments when calculating practice savings to account for the support it provides to practices. According to a Medica interviewee, “We know that we are incurring costs, but hoping that our share of the savings will cover those upfront costs.”

Medica and Fairview also award shared savings to each practice based on its performance on all services compared with a control group: the average performance of other large-group practices in the metropolitan area. They base this comparison on quality measures that serve as a qualifying gate that enables practices to receive savings. A confidential algorithm then determines the shared-savings pool based on health care quality, cost, efficiency, patient experience, and provider collaboration among qualifying practices.

Fairview takes 75 percent of the calculated savings, while Medica receives the other 25 percent. Fairview then distributes its share as follows: one-third to the hospital, one-third to care management infrastructure, and one-third to providers in the system. Fairview adjusts the management fee to include the self-insured population. Medica and Fairview calculate these shared savings annually.

Medica and Fairview have also identified an “optimal group” that delivers the most cost-efficient and high-quality care, to help practices identify opportunities for improvement and monitor performance.

Adjusting for Patient Risk

Medica uses the ACG grouper to account for variations and changes in the risk profiles of each practice’s patient population. It also truncates the annual health care costs of an individual at \$250,000 or \$500,000, depending on the contract. That is, Medica does not include per-patient costs beyond that amount when calculating cost savings.

Technical Assistance

Medica relies on a handful of full-time analysts to present a robust analysis of the costs incurred by the patients of each provider group each month. For example, Medica might identify spine surgery as a high-cost, high-volume procedure, collect and analyze data on the use of that surgery during a given month, and then discuss the results with leaders and physicians in each provider group. Medica also provides dedicated support to each group through a care manager or health coach, depending on the group’s needs.

Fairview appreciates the commitment of Medica and other payers to sharing information, but prefers to receive raw data in real time rather than reports. Fairview prefers to perform its own analysis to help providers manage their patient population most efficiently.

Medica’s Experience with the Shared-Savings Model

Medica has been evaluating and tweaking its model, and is encouraged by preliminary drops in the cost of treating patients with chronic diseases.

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE (PROMETHEUS PAYMENT)

The Health Care Incentives Improvement Institute (HCI3), a nonprofit think tank that develops programs and tools to facilitate health care reform, used a three-year grant to pilot a shared-savings program applied to the Prometheus Payment bundled payment methodology. HCI3 has piloted this approach with three payers, which were free to develop variations.

HealthPartners, a nonprofit HMO in Minnesota that also operates multipayer clinics, ran the first shared-savings program with four provider networks in 2009. That pilot included only health care services related to acute myocardial infarction.

Employers' Coalition on Health, a nonprofit PPO headquartered in Rockford, Illinois, began the second pilot in 2010. Intended to run through 2012, that program is focusing on health care services related to diabetes, hypertension, and coronary artery disease, at least initially.

Independence Blue Cross and Crozer-Keystone—the latter a nonprofit integrated provider—began the third pilot in Pennsylvania in the first quarter of 2010. That program has focused on procedures related to hip and knee replacements, at least initially.

Why Shared Savings?

HCI3 has implemented Prometheus Payment with a shared-savings approach as a transition to a more complex, risk-sharing system that might otherwise represent a daunting leap for providers. HCI3 worried that providers might fear that such risk-sharing approaches would leave them owing money to payers at the end of the year, or even push them into insolvency.

Shared-Savings Methodology

Patient Population: Attribution and Minimum Size

Prometheus-based shared-savings pilot programs have not required health care plans to attribute patients to specific provider groups. However, the programs apply only to particular medical procedures and chronic health conditions.

To qualify for shared savings, practices must perform at least 30 of each included procedure each year, and must serve at least 100 chronic-care patients with each included condition. HCI3 acknowledges that these minimums are low by some standards. However, it contends that a sensitivity analysis of the algorithms used to calculate health care budgets (see below) supports those minimums.

Determining and Distributing Savings

HCI3 uses Prometheus Payment to set a budget for the expected costs associated with a procedure, or treatment for a chronic condition. The budget incentivizes providers to reduce potentially avoidable complications (PACs), and therefore health care costs. A retrospective calculation assesses whether providers' actual spending fell below or exceeded the budget.

Like most other shared-savings programs, HCI3's does require providers, particularly hospitals, to assume some risk, in that they must invest in changing approaches that affect all patients—not only those covered by the shared-savings agreement. These shifts may mean that providers lose some fee-for-service revenue for patients not covered by the shared-savings agreement.

Prometheus uses an algorithm that calculates a risk-adjusted, per-case PAC budget based on “evidence-informed case rates” for each covered treatment or condition. (The algorithm is based on a multivariate regression model developed by HCI3.) Providers are accountable for the costs of all care for all episodes related to contracted conditions and treatments.

HCI3 suggests that payers ask providers to reduce PAC costs by 50 percent compared with budgeted costs, and further suggests that payers give providers a PAC allowance—50 percent of the per-case PAC budget—up front. Unlike many other shared-savings arrangements, that essentially means that payers prospectively withhold a portion of the budget. However, providers never have to return any of the allowance to payers.

At the end of the year, Prometheus scores providers on a 100-point scale measuring their success in

reducing PAC costs. That score determines their end-of-year payouts from the withheld portion of the budget. To receive any payout, providers must reduce PAC costs compared with the budget by at least 6 percent. Payers can also make payouts contingent on a provider's score on a quality scorecard developed by HCI3 using external benchmark data, though none of the pilot programs are implementing that option.

Payers are free to set PAC allowances higher than 50 percent of the budget—that is, to withhold less or even none of the PAC budget. However, HCI3 strongly discourages payers from setting PAC allowances lower than 50 percent of the budget, to ensure that the target is not too daunting, and that providers have some financial cushion against unexpectedly high PAC costs. HCI3 says it might lower suggested allowances in the future.

HCI3 reports providers are likely to prefer this overall approach to a program that measures their performance against a control group, because the budget gives them a stationary target and allows them to continually assess where they stand. HCI3 also believes that provider groups will consider the shared-savings program a success even if they fail to earn a payout, if it leads them to reduce PAC costs.

HCI3 acknowledges, however, that payers might reasonably object to sharing savings based on a fixed budget during a period when non-program providers could achieve the same savings. In that case, a control-group approach would seem fairer to payers.

Adjusting for Patient Risk

HCI3 recommends protecting providers against exceptional costs related to any one medical episode by employing a stop-loss provision, and truncating costs for episodes that exceed two standard deviations of the expected cost.

Technical Assistance

HCI3 provides all services and tools needed to implement the methodology. These include budgeting PAC costs and determining PAC savings, scoring providers, and producing quarterly reports that allow providers to assess their performance compared with the budget. HCI3 also provides advice on improving health care processes, and enables payers and providers to share budgeting and performance data and other information.

HCI3's Experience with the Shared-Savings Model

In the first pilot program, participating providers came in 1 percent over budget, and therefore did not receive any payout. As of the date of the interview, HCI3 had not yet calculated savings for the other two pilots, but the highest score among providers so far was 72 out of 100. If providers sustain that score, they would receive 50 percent of the withheld PAC budget—or 25 percent of the total PAC budget.

HCI3 says it is satisfied with these results, on balance, because the program has spurred desired behavioral shifts among providers. HCI3 emphasizes that transitioning to a shared-risk approach will further fuel behavioral change and ensure the financial viability of the payment model. HCI3 advises other organizations considering a shared-savings model to spell out the “glide path”—an explicit timeline—for moving to sharing downside risk with payers and providers.

BLUE CROSS BLUE SHIELD OF ILLINOIS AND ADVOCATE HEALTH CARE

Blue Cross and Blue Shield of Illinois (BCBS IL) is the largest health insurance company in the state, insuring more than 6.5 million members. BCBS IL offers a full range of products for individuals, families, employer groups, and seniors, including a shared-risk HMO with more than 800,000 members served by some 75 physician groups. BCBS IL has received accreditation from NCQA and the Utilization Review Accreditation Commission.

Advocate Health Care, a faith-based, not-for-profit system based in Oak Brook, Illinois, is the largest integrated health care system in the state, and one of BCBS IL's largest networks of provider practices. Advocate encompasses more than 250 care sites, including 10 acute care hospitals and two integrated children's hospitals.

BCBS IL began a shared-savings program in 2011 with Advocate for services delivered to members of a PPO, most in a seven-county Chicago area, plus one hospital in Bloomington, Illinois. Two groups of Advocate primary care physicians are participating in this program: employed physicians, and 900 doctors in a physician hospital organization, for a total of 3,500 physicians.

Why Shared Savings?

BCBS IL and Advocate both recognized that the current health care cost structure was unsustainable. According to an Advocate interviewee, "We wanted to systematically eliminate waste through various initiatives (decreasing ER visits, shortening length of stay, managing ambulatory-sensitive conditions to avoid admissions). We believed that by working collaboratively we could develop a creative approach and step outside the usual adversarial relationship between providers and payers."

BCBS IL cited several reasons for choosing Advocate as a partner. First, it was both a high-quality and a high-cost provider. Second, Advocate's historic commitment to improving health care quality and infrastructure reassured BCBS IL that the organization

would deliver high-quality care even with incentives to reduce costs. Third, BCBS IL and Advocate have several years of successful experience with a shared-risk arrangement BCBS IL uses with HMOs.

Shared-Savings Methodology

Patient Population: Attribution and Minimum Size

The shared-savings arrangement applies to members enrolled in fully insured and self-insured commercial PPOs.⁵ The pilot excludes members insured under the Federal Employees Health Benefits Program.

BCBS IL uses a confidential methodology, developed with Advocate, to attribute patients to a provider group based on a two-year look-back and a tie-breaking algorithm. BCBS IL shares reports of attributed populations on a monthly basis with Advocate, and the December 2011 attributed population was to be used for its initial shared savings calculation.

BCBS IL has set no minimum size for the patient population of participating provider groups. However, BCBS IL sought a provider with a substantial population for this first arrangement with an accountable care organization.

Determining and Distributing Savings

Advocate and its physicians must fulfill two requirements to receive shared savings: they must reduce costs and achieve quality outcomes. For the first requirement, BCBS IL compares baseline medical costs for the attributed population to the medical costs of patients served by the rest of BCBS IL's PPO network. To qualify, Advocate's trend must be lower than the risk-adjusted trend of the nonparticipating PPO network by more than a predefined amount.

After Advocate has fulfilled this requirement, participating physicians must also meet minimum quality thresholds to receive shared savings. In the first year of the new approach, Advocate physicians had to maintain performance on 12 quality measures, and faced penalties if performance declined. In the second and third years, Advocate and BCBS IL planned

⁵ Commercially insured HMO members are in a different type of full-risk contract with BCBS IL.

to negotiate targeted increases in an expanded set of measures.

If Advocate achieves overall savings and participating physicians pass the quality “gate,” they are eligible to share up to about 50 percent of the cost savings—minus a confidential percentage set aside to offset BCBS IL’s investments in infrastructure. To ensure a transparent process, BCBS IL has given Advocate the right to audit its calculations.

Adjusting for Patient Risk

BCBS IL uses DxCG software to account for variations and changes in the risk profile of Advocate’s patient population. However, BCBS IL has chosen not to limit the risk that providers face for patients with extremely high costs, because the number of patients covered by the shared-savings arrangement is large, and BCBS IL assumes that a normal distribution of patients will occur across providers.

However, BCBS IL excludes the costs of a few high-cost services, such as transplantation, from the savings calculations. When determining the cost trend for the nonparticipating BCBS IL network, to compare with Advocate’s costs, BCBS IL also excludes very low-cost claimants whom it could not attribute to a provider.

Technical Assistance

Participating practices receive reports, data feeds, and access to software tools that allow them to download data directly into their electronic medical record systems. BCBS IL also provides analytical support on treating targeted groups of high-risk members.

BCBS IL’s Experience with the Shared-Savings Model

While the model is still relatively new, BCBS IL believes that its basic framework—especially the quality targets—is sound. Although it notes that the methodology may evolve, BCBS IL hopes that participants in other markets can use it as a template.

HEALTHPARTNERS

HealthPartners is the largest consumer-governed, non-profit health care organization in the nation, covering more than 1 million members in Minnesota, western Wisconsin, North Dakota, and South Dakota. The regional network includes more than 38,000 doctors and other care providers. NCQA has awarded HealthPartners its highest rating, and ranked it among the top 10 percent of commercial health plans in the nation in 2010–2011. The National Business Coalition on Health has also ranked HealthPartners as the best in the nation on its *eValue8* assessment.

In 2009, during its contract renewal process, HealthPartners began developing shared-savings arrangements with all major care systems in its network that were subject to total-cost-of-care approaches to payment. (These systems include Fairview Health Services—see the [Medica–Fairview case study](#).)

Why Shared Savings?

HealthPartners chose shared savings as an expression of its dedication to the Institute for Healthcare Improvement’s triple aim: to improve the quality of care, the health status and care experience of each individual, and the affordability of care. HealthPartners views shared savings as an incremental step toward more comprehensive risk-sharing with providers.

Shared-Savings Methodology

Patient Population: Attribution and Minimum Size

HealthPartners’ shared-savings arrangement applies to members enrolled in commercial, fully insured, and self-insured PPOs and HMOs. Two care systems also opted to include their Medicaid-insured members. HealthPartners uses a confidential internal methodology to retrospectively attribute members to a primary care provider.

HealthPartners has set no minimum size for the patient population of participating providers, because it now contracts only with large groups of physicians. However, if HealthPartners begins to contract with smaller physician groups, it would look to the Centers for Medicare and Medicaid Services

for guidance on an appropriate minimum patient population.

Determining and Distributing Savings

HealthPartners compares each care system's performance to a jointly negotiated target. The average per-patient cost of care in a metropolitan area is the negotiated target for one system. HealthPartners calculates savings by comparing the performance of participating practices to the costs of all health care services in the target. The organization calculates shared savings for commercially insured and Medicaid-insured patients separately.

Providers and the plan share any cost savings equally. Unlike some shared-savings arrangements, HealthPartners does not recapture plan costs associated with the arrangement, require reinsurance to protect against high-cost outliers, or have a minimum savings threshold.

Adjusting for Patient Risk

HealthPartners uses the ACG software to account for variations and changes in the risk profile of the patient population of each provider group. Health Partners has also chosen to truncate the costs of high-cost patients, although the dollar level is confidential.

Technical Assistance

HealthPartners gives each provider a sophisticated report analyzing health care use and costs by condition, place of service, and specialties. The report also compares these results to those of other providers in the region, to suggest opportunities for improvement. HealthPartners meets with providers to review these reports. HealthPartners also provides some grant funds to help physician groups build the capacity to succeed in this shared-savings arrangement, and to cover their costs of implementing it.

HealthPartner's Experience with the Shared-Savings Model

HealthPartners had just begun calculating shared savings when we interviewed plan officials, and did not yet have findings. A Health Partners interviewee noted that "Some [providers] initially opposed [the arrangement], but we are having a lot more success over time."

The interviewee also observed that transparency in all aspects of the approach is critical, and recommended that organizations strive to ensure that all participants benefit. HealthPartners offered to share its experience with other payers and providers interested in pursuing a shared-savings arrangement.

HARVARD PILGRIM HEALTH CARE

Harvard Pilgrim Health Care (HPHC) is an independent, nonprofit health plan with some 1 million members in New England, and the second-largest health plan in Massachusetts. HPHC offers a variety of plan options for employers, families, and individuals, including fully insured and self-insured plans and traditional HMOs. A subsidiary of HPHC, Health Plans, Inc., is the largest third-party administrator in New England.

In the first quarter of 2010, HPHC adopted a shared-savings model for its HMO members—a large percentage of its total membership—with a large provider network affiliated with an integrated health care delivery system. HPHC has since made the shared-savings model available to other providers. It is a standing option in an array of approaches to payment used by HPHC, which include full-risk options and traditional fee-for-service with pay-for-performance incentives.

Why Shared Savings?

HPHC introduced shared-savings contracts with provider groups for three reasons. First, the health plan wanted to focus the attention of smaller and midsized medical groups on managing the use and cost of health care services without requiring them to assume financial risk, which can be hazardous for small groups because of the volatility of medical costs.

Second, the plan believed that shared savings could serve as a bridge to a shared-risk model for larger medical groups. Finally, HPHC was concerned that practices would agree to shared-risk or full-risk arrangements before they were prepared to manage them.

Shared-Savings Methodology

Patient Population: Attribution and Minimum Size

HCHP uses an internally developed methodology to assign patients to provider groups. Providers must serve at least 3,000 patients to participate in the shared-savings arrangement.

HCHP acknowledges that this figure is lower than what actuaries might desire. However, the plan wants to offer the approach to many providers, and believes that any risk it would incur is worth taking relative to the fee-for-service status quo. HPHC also believes that payers need to afford providers a fair amount of leeway in the early years of shared-savings arrangements.

Determining and Distributing Savings

HPHC builds a health care budget for assigned patients based on the two-year average costs of a provider group. The plan also considers a multiyear cost trend for the network as a whole, and negotiations with each provider group, when creating this budget.

HPHC assesses providers' performance every 12 months by comparing it to the average costs of that medical practice over the previous two years. HPHC uses this average to take into account random variation in the use and cost of care among the patients of a practice.

If the group reduces health care costs compared with the budget, HPHC retains the first 2 percent of those savings to account for variation in medical expenses across time, and for the absence of downside risk. HPHC then gives 50 percent of any remaining savings to the provider group, up to a maximum of 6 percent of the target. That means that a provider can receive up to 3 percent of the budget target as shared savings.

Unlike many other shared-savings arrangements, this approach does not tie payments to any performance targets. HPHC maintains a preexisting pay-for-performance program that coexists with the shared-savings model to provide separate bonuses for high-quality performance.

Adjusting for Patient Risk

HPHC uses DxCG software to account for variations and changes in the risk profile of patient populations. HPHC excludes patients with costs above \$100,000

from the provider's population when calculating savings. The plan also excludes certain services, such as behavioral health and transplantation, from the calculations. Under the shared-savings model, HPHC assumes all reinsurance costs.

Technical Assistance

Before HPHC begins to share savings with a provider group, it assesses its readiness to handle this new payment model. HPHC uses an internally developed assessment tool to determine whether the practice has the clinical expertise and leadership to manage care for its overall patient population.

After the assessment, HPHC offers technical assistance to further prepare practices for this new model. HPHC gives them access to basic reporting tools to track their own performance, examples of best practices, and medical leadership, all at no cost. For a fee, practices also have access to other tools and technical assistance, such as care management, hospital utilization review, and the production and distribution of more in-depth reports.

HPHC's Experience with the Shared-Savings Model

HPHC believes that its shared savings model will remain a long-term option for some provider groups. HPHC believes in building a collaborative relationship with providers, and has no intention of forcing groups into this or a full-risk payment model.

In fact, HPHC believes that provider groups with historical efficiencies can remain in the fee-for-service model while receiving pay-for-performance bonuses. HPHC's collaborative approach also includes negotiating with providers so they have a fair and reasonable say in setting budgets and basic fees for service.

CONCLUSION

These six case studies reveal consistent themes regarding shared-savings approaches to payment for health care services. These common elements include a willingness among most payers to absorb many of the costs entailed in setting up and sharing tools for measuring health care performance and cost savings. Overall themes also include a belief that shared-saving programs must evolve to include shared risk, and a conviction that even when pilot programs fail to achieve savings, they are moving in the right direction.

We do not yet know whether this approach is a long-term strategy for promoting better health care while lowering costs, or a transitional strategy to some other model, such as global payments involving shared risk. Exploring the organizational and environmental differences in how participants pursue shared-savings approaches, and the outcomes they achieve, will be key to determining whether they work, how to improve them, and whether and how to diffuse them.

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