



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

Shared Savings

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the nine payment methods discussed in the report *Payment Methods: How They Work*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

Shared Savings

The shared savings method has been introduced partly to give providers an “on-ramp” or “training wheels” for moving away from fee-for-service payment. This form of incremental payment, which some consider a form of pay-for-performance focused primarily on spending reductions, is commonly associated with accountable care organizations (ACOs). Yet, the generic approach may be applied to any type of provider organization. In current Medicare and commercial insurance demonstrations, shared savings reward or possibly penalize (shared risk) ACOs for their spending performance (in relation to spending targets for a population of patients attributed to the ACO). In this method, essentially, base payments continue using established methods (typically, fee schedules for professionals, DRGs or per diems for hospitals), while ACO entities can receive additional payment if their spending for beneficiaries is lower than a target. When the ACO achieves savings, it can then distribute its share (possibly adjusted by performance on a set of quality measures) to its constituent members.

Shared savings programs can be characterized as “upside-only” (“one-sided”) risk or “upside-and-downside” (“two-sided”) risk which here we have labeled “shared risk”. Consistent with the training-

wheels notion, most ACO arrangements start with upside-only risk and migrate to shared risk over time, once the ACOs have had some experience with shared savings. Some shared savings programs, including Medicare's, require a "minimum savings threshold," which separates spending reductions due to successful ACO efforts from spending reductions due to random variations; the more people assigned to the ACO, the lower the threshold for receiving shared savings. Shared risk models generally give ACO providers a larger percentage of savings bonuses in exchange for the financial risk they are willing to assume.

An essential part of the shared savings approach as applied to ACOs is reliance on quality performance measures. An ACO's performance on quality measures determines how much of a bonus it is eligible to receive for reducing spending against its target. In contrast to many P4P programs that target individual providers, ACO shared savings programs use measures that reflect the quality the ACO provides its patient population.

A fundamental difference between global capitation and shared savings and shared risk approaches is that the former is a base spending method and includes most revenues a payer provides the recipient organization, whereas the latter provides incremental reward or penalty placed on top of other base payment methods—usually the legacy payment methods of fee schedules for physicians, DRGs or per diems for hospitals, and so on. Therefore, the incremental shared savings approach does not offer providers the same opportunity to change their business models and cultures or furnish the same predictable cash flow to support change. (The Medicare Advance Payment model attempts to address this deficiency for small organizations participating in Medicare shared savings programs for ACOs.) Also, global capitation typically pays based on a marketwide average for all providers, whereas shared savings approaches typically rely on each ACO's historic spending as the base, at least initially.

The update factor needed to trend the ACO's historical spending for inflation can be determined in various ways. Payers can use a matched patient control group to determine the rate of increase applied to the target group's historic spending. More commonly, an external factor, such as an estimated trend in overall health care spending, is used to establish the applicable spending target. In most formulations, both historic target spending levels are risk-adjusted for age, sex, health status, and possibly other factors such as socioeconomic ones.

Key Objectives

Shared savings is generally viewed as a practical, transitional payment model to grant providers experience with incentives to spend more prudently on health care services. Many payers, including Medicare, propose an evolution from fee-for-service to upside-only to shared risk, and perhaps ultimately, to more robust forms of population-based payment such as global capitation. Taking their lead from Medicare, most payers' shared savings programs also place primacy on using the approach to assure quality improvement, as shared savings don't flow to the recipient provider organization unless it meets quality performance thresholds—an element that has not been central in capitation payment arrangements in the past.

Strengths

- One-sided shared savings does not require provider organizations to take on major financial risk, something many such organizations—especially small organizations—are not in a position to do. It establishes gentler, perhaps more realistic, positive incentives that can provide a reasonable entry for organizations that are new to risk-bearing and lack capital to manage global capitation.
- The approach to using historic spending as the base for spending targets may be more practical for many organizations whose spending exceeds the average. Shared savings presumably targets “low-hanging fruit”—savings that may be easier to achieve from a high base.
- One-sided shared savings can generally be adopted under PPO arrangements because of the absence of risk taking.
- The “on-ramp” concept makes sense. With the experience gained, ACOs that improve under upside-only shared savings should naturally evolve into working toward the stronger incentives of shared risk.
- Shared risk fundamentally changes volume-based incentives much as capitation does, but may be more practical to implement. Routine cash flow continues under established payment methods, so the ACO need not take on the challenging role of paying its constituent provider members (although it still needs to decide how to share any savings earned with its members.)

- The central role of population-based quality metrics provides some assurance that spending reductions will not compromise quality.
- Models that attribute individuals to ACOs typically do not lock patients in to a particular primary care physician responsible for approving referrals. Most programs either do not limit choice at all (e.g., Medicare) or are placed on a PPO product platform that has gentle benefit design incentives to influence provider choice.
- Even short of a fundamental reorientation to providing care, provider organizations under shared savings can adopt relatively straight-forward approaches (e.g., improving transitions of care from hospital to community, coordinating care for patients seeing many different providers, adopting evidence-based guidelines).

Weaknesses

- The dominant, base payment methods used in shared savings models remain volume based. Expecting the small incremental incentives placed on a separate or intermediary ACO organization to reduce spending (to counter the volume-inducing incentives of the underlying payment system) may be unrealistic.
- Using unadjusted historic spending to determine spending targets is unfair to organizations that have had above-average performance on spending, as they have less room to achieve additional spending reductions.
- Similarly, under shared savings, there is a law of diminishing returns after the “easy savings” have been achieved. The maintenance of volume-based payment models—especially under one-sided shared savings—could actually make it more difficult to achieve the major changes in providers’ business models and cultures that are the goals of stronger payment approaches such as global capitation.
- Operationally, determining whether and to what extent savings have actually been attained can be challenging. The Medicare ACO program has been subject to criticism for its retrospective attribution of patients for which the ACO is responsible and for its non-intuitive calculation of shared savings bonuses.

- As with global capitation, ACOs may need to consolidate and integrate to have sufficient size and scale to meet requirements under shared savings and shared risk methods. This may empower organizations to use their newfound organizational clout to negotiate higher prices for the base payments that determine most of constituent members' revenue—as well as strengthen their negotiating position with other payers that don't participate in the shared savings arrangement.

Design Choices to Mitigate Weaknesses

There are many operational challenges in implementing shared savings and shared risk for integrated care organizations accountable for cost and quality for a population:

- how patients will be attributed to an ACO and whether freedom to choose a provider will be limited, if granted at all
- whether patients should share in savings
- setting any minimum savings threshold ACOs will have to meet before they can share in savings
- the selection of applicable quality measures
- if and when to require two-sided risk
- whether to apply risk corridors to provide financial protection when ACOs do accept risk
- how to evolve the payment target from on an ACO's historic costs trended forward to some consideration of market-based, average costs
- providing the right balance between the percentage of savings providers keep (to provide incentives to participate) and the savings payers keep (to make shared savings worth the effort)

Often ignored in shared savings discussions are the underlying payment methods that provide ACO constituent providers with basic payments. Reforms targeted to these legacy payment models can complement the shared savings overlay. But, typically, these are given little attention because the marginal rewards (or penalties) associated with shared savings are the focus. For example, there is a broad perception that physician fee schedules overpay for tests and procedures, at the expense of communication with patients and other professionals, thereby making the ability to reduce spending more difficult. These distortions create conflict between the ACO and some constituent physicians.

Correcting flaws in the design of these base payment methods could facilitate the savings the ACO is trying to achieve.

Compatibility with Other Payment Methods and Benefit Designs

As an incremental payment approach, shared savings provides bonuses and shared risk bonuses and penalties compatible with a range of base payment methods. The savings calculation is based on spending regardless of the form of payment, except for global capitation (which provides a fixed payment, making shared savings calculations unnecessary).

Because shared savings does not alter the basic payment methods and payment rates, it is not incompatible with various cost-sharing options (as global capitation is). At the same time, shared savings, like global capitation, is also a supply-side strategy: it offers provider organizations incentives to actively assess medical need and reduce avoidable services, rather than relying on consumers to become smarter shoppers for services.

The Focus of Performance Measurement

The most prominent use of shared savings is with ACOs. A significant goal of the Medicare approach, which has been largely adopted by private insurers and some Medicaid programs, is to introduce performance on quality measures as an essential element of the model; ACOs do not get to keep savings or have a smaller share of savings based on their quality performance. The rationale is straight-forward: ~~incentives in shared savings and, indeed, even more in shared risk and capitation~~ can produce stinting on care ~~(even more so in shared risk and capitation)~~, ~~withholding important, (usually non-urgent), services which-that~~ largely prevent adverse health outcomes months or years later. Measures related to organizational performance for caring for population health are also desirable in the context of ACOs with shared savings or shared risk incentives. For both of these objectives ~~-(assuring provision of primary and secondary prevention services and measuring population health for specified individuals)~~, measures are available and, likely, statistically valid if measuring at ~~the-across~~ ACO organizations ~~level~~, rather than ~~the~~ individual health professionals.

However, consumers are also concerned that payment methods that encourage more prudent health care spending will ~~result in~~lead to a reduction in desirable referrals to physician specialists and other health professionals with specialized expertise, especially if those providers are not part of the ACO network. At this time, there are no performance measures related to appropriateness of referrals. Network adequacy requirements may help ~~assure~~ensure that specialized expertise is available within a network such as those in an ACO. However, availability does not assure appropriate referrals are made or that patients are informed about their referral options.

Potential Impact on Provider Prices and Price Increases

The horizontal and vertical integration ACOs represent can be used to increase pricing power in negotiations with private payers over physician and hospital prices. This counters the cost savings objectives of the shared savings approach. Medicare-approved ACOs will still be subject to antitrust scrutiny for exceeding provider concentration benchmarks, and they can be prevented from entering commercial insurance markets even if they function as Medicare ACOs. However, arguably, antitrust enforcers will find it more difficult to prevent a successful Medicare ACO from participating as an ACO with private insurers. A successful Medicare ACO, even less likely to be subject to antitrust scrutiny, might be able to negotiate higher prices with private payers without attempting to become an ACO with those payers.

For commercial insurance, in contrast to public payers, shared savings is based on spending targets, which themselves are based on historic costs trended forward. This method actually accepts and “bakes in” pricing differentials that the constituent providers have been able to negotiate. The shared savings approach might moderate price increases, but not necessarily, because providers’ prices might well be higher than their share of savings from beating spending targets. Further, as under global capitation, a physician group without a commitment to a particular hospital or hospital system can aggressively shop on price, assuming quality is equal. By actually moving or threatening to move patients from one hospital to another, a capitated physician group can achieve price concessions from hospitals seeking to preserve or increase their market share of bed days and outpatient services. Of course, again, physician group shopping can occur only in reasonably competitive markets such that the threat of moving patients is credible.

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A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

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