

Is “Shared Savings” the Way to Reform Payment?

There is growing interest in using “shared savings” as an approach to healthcare payment reform. Medicare has used it as the key element of its Physician Group Practice Demonstration, and it has been proposed as the key mechanism for encouraging the creation of “accountable care organizations.”

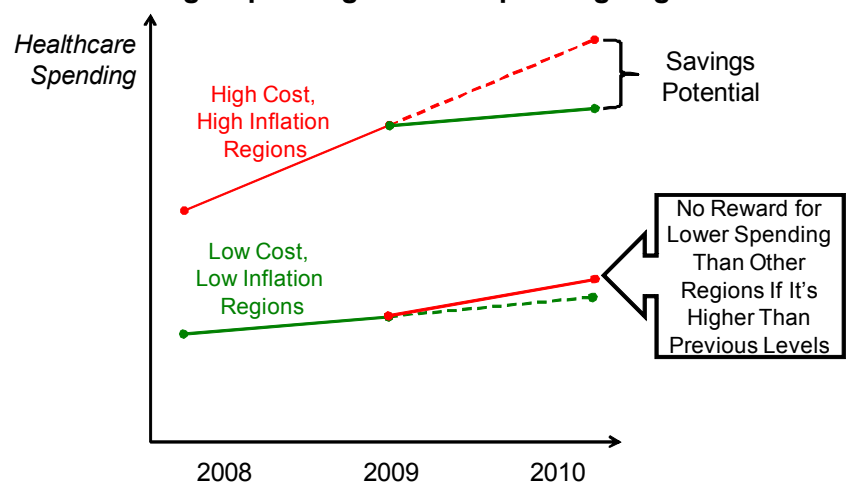
The basic concept is fairly simple: if a healthcare system or provider reduces total healthcare spending for its patients below the level that the payer (e.g., Medicare or a private health insurance plan) would have otherwise expected, the provider is rewarded with a portion of the savings. The result is that the payer still spends less than it would have otherwise, and the provider gets more revenue than it would have otherwise expected.

The Trouble With Shared Savings

Unfortunately, there are some fundamental weaknesses in the shared savings approach that make it far less desirable as a payment reform than it might first appear:

1. **It’s P4P, Not Fundamental Payment Reform.** Shared savings is just another form of pay-for-performance (P4P). It doesn’t actually change the current payment system at all – key primary care services that aren’t paid for today (like nurse care managers for chronic disease patients, phone and email consultations with physicians, etc.) still wouldn’t be paid for, services where fees are too low to cover costs would still lose money, etc. Creating an incentive for providers to control total spending is a good idea, but only if it is coupled with significant changes in the underlying payment system.
2. **It Gives Providers Risk Without Resources.** At first glance, shared savings looks like the perfect deal for the healthcare provider – if the provider is successful in reducing total costs, it gets a bonus; if it’s not successful, it suffers no penalty. The flaw in the logic is assuming that there is no cost to the provider of doing what is needed to achieve success. For example, although there are programs that have been demonstrated to reduce preventable hospitalizations, most of these programs require an increase in upfront spending by the primary care practice or the health system that implements them, or they take time away from other revenue-generating tasks. The shared savings payment might ultimately cover those costs or it might not, and so the provider has no assurance that its increased costs will be covered. Moreover, when multiple providers are involved, shared savings creates a variant of the “prisoner’s dilemma” – if one provider makes the investment to improve care but others don’t, the total savings may not be sufficiently large to insure the shared portion will cover an individual provider’s costs; conversely, if most providers make the investment, any individual provider can increase their profit by sharing in the savings without making any upfront investment themselves.
3. **It Rewards High Spenders Rather Than High Performers.** The communities and providers that have the most to gain from shared savings are the ones that are “wasting” the most resources today, through high rates of hospital admissions, use of unnecessary procedures, etc. In contrast, the communities that are the nation’s best performers – those with relatively low costs and high quality of care – are already “saving” Medicare and other payers significant amounts of money, but

Impact of “Shared Savings” Models in
High-Spending vs. Low-Spending Regions



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they receive no reward for doing so. The first group can improve relatively easily, since they have so much "low-hanging fruit" to pursue, and therefore would be eligible to get a large reward through a shared savings model. The latter group, even if it can still improve further, may need to invest significantly more resources to do so; this would require it to spend more in the short run, but with a lower probability of achieving enough savings to pay back those costs. In effect, shared savings exacerbates the current inequities in the payment system. The problem is even worse if the payer chooses to take a disproportionate share of the savings first, as Medicare has done in the Physician Group Practice Demonstration. Although this is intended to avoid rewarding providers for reductions in spending simply due to random variation, the practical effect is to increase the amount the provider has to spend or lose before receiving any reward through shared savings.

4. **A Smaller Reduction in Revenue is Still a Reduction.** In order for the payer (e.g., Medicare) to have any savings at all, some provider has to get less revenue than it would have otherwise received. If that provider is participating in the effort to reduce spending, giving them back an arbitrary share of the savings reduces the amount they lose, but they may still get less revenue than their actual cost of delivering services, which will discourage them from participating in the effort to create the savings in the first place. Moreover, if only one payer is sharing savings but the provider changes its approach with all of its patients, the shared savings program may offset only a small portion of the provider's losses.
5. **It's Not a Sustainable Approach.** What happens after the initial savings have been achieved and shared? Even if costs remain lower than would otherwise have been expected, nothing has changed about the underlying payment system, and it will be hard for payers to continue making special "shared savings" payments indefinitely based on savings achieved in the past, particularly as the providers and their patients change over time. This will deter providers from making large investments in care improvements that would need to be paid off over a multi-year period.

The Right Way to Share Savings

Sharing savings makes sense as part of a transitional strategy for payment reform, but it needs to be done in (at least) two specific ways:

- **Payers and Providers Sharing Risk for High-ROI Value-Improvement Programs.** In other industries, bankers and investors commit upfront capital to companies which present a business plan showing how that capital will be used to generate a financial return-on-investment (ROI). A similar approach is needed in the healthcare industry: if a provider can present a business plan for generating savings for a payer, the payer should commit a portion of the expected savings as an upfront payment to enable the provider to carry out the plan, as long as the provider accepts accountability for achieving the expected savings and shares in the risk if the savings do not materialize. For example, if a physician practice wants to implement a program to hire care managers or patient coaches to help reduce hospital admissions or readmissions among chronic disease patients, the payer(s) would advance a portion of the savings expected to result from the reduced hospitalizations to enable the practice to hire (or contract for) the care management/coaching staff. The practice would agree to pay back all or a portion of the funds that were advanced if the program failed to achieve its goals.
- **Recalibrating Hospital Payment Levels.** If the country is going to achieve any significant savings in health care, much of those savings will need to come from slower growth or reduced spending on hospitals, since hospitals are the largest contributor to healthcare spending increases. But lower utilization of hospitals means that hospitals will have higher *per-patient* costs, particularly in the short run, because they will need to spread their fixed costs across a smaller number of patients and patient-days. As a result, unless some of the "savings" achieved by payers goes back to those hospitals in the form of higher payments per case, the hospitals will lose money on each case. This, in turn, could potentially cause negative margins for the hospitals and adversely affect their ability to deliver quality care. Although it may seem counter-intuitive to suggest that payment levels to hospitals should be increased as part of an effort to reduce healthcare spending, the payer would still save money because the slightly higher payments would still be more than offset by the lower rate of utilization of hospital services, and the hospital would be paid a new rate that better matches its new cost of delivering services. This is fundamentally still "sharing savings," but in a much more targeted and less arbitrary way.

Although these approaches can be used as a way of improving Fee-for-Service payments, it makes more sense to change the payment system entirely, using Episode-of-Care or Comprehensive Care Payment systems wherever possible. Under an Episode-of-Care Payment system, providers automatically benefit from any savings they generate through improving efficiency *within* episodes, and under a Comprehensive Care Payment system, providers can also benefit from the savings they achieve through preventing unnecessary episodes of care. The payer saves by paying less per episode or per patient than it did in the past, and moreover, it knows upfront how much it will be saving, rather than having to wait to see whether any savings will be achieved.



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