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American Hospital Association

CENTER FOR HEALTHCARE GOVERNANCE

Two Paths to Savings

Shared savings and gainsharing increase value in health care but use different strategies. Is one — or are both — right for your hospital?

By Jo Surpin and Anthony Stanowski

Shared savings and gainsharing are opportunities for hospitals to increase the value of the care they provide. But while the terms often are used interchangeably, the programs function in unique ways. For example, their incentive structures differ and they require distinct physician strategies. The programs also have different levels of risk. For boards, understanding the benefits and drawbacks of both initiatives will help them to evaluate each program in light of their organizations' risk tolerance, guide resource allocation and lead the culture change required of physicians.

Let's take a look at how shared savings and gainsharing work by examining four basic questions:

1. How do shared savings and gainsharing differ?
2. Can hospitals and health systems participate in both?
3. How are incentives distributed in each?
4. How are the success requirements different?

1. Program Differences

Shared savings programs focus on the revenue, or payment, side of the equation. They enable insurers to decrease spending by incenting providers to use the lowest-cost service for their patients to achieve desired outcomes.

The Affordable Care Act authorizes two forms of shared savings: accountable care organizations and bundled payments. The ACO concept is similar to an HMO as a population-based payment structure. Most bundled payment programs are comparable to DRG or case payments, but they are broader because the payment includes hospital inpatient, outpatient and post-acute service payments as well as payments to physicians. If providers who serve that population (or provide services in a bundle) are able to deliver care in such a way that the insurer does not have to spend as much treating the population, then the providers share in a portion of the insurer's savings, based upon an agreed distribution methodology.

Gainsharing, on the other hand, focuses on cost reduction. In the corporate sector, companies use gainsharing to increase profitability by motivating employees to improve their performance. Hospital gainsharing arrangements provide incentives to physicians (who may or may not be hospital employees) to decrease inpatient costs based on improvement from the prior year and on implementing best practices. Then, hospitals reward participating physicians with a portion of the cost reduction. Gainsharing payments are only attributable to reductions in hospital cost; they are not based on profitability, so it is not a profit-sharing arrangement.

In both cases, incentives drive the initiatives. In shared savings, the incentives focus on decreasing overall utilization of health services by a population to meet a target price as set by the payer. This results in a decrease in revenue for inpatient services through efforts designed to avoid admissions, reduce readmissions and improve care coordination. In contrast, gainsharing's focus is to reduce costs when a patient is admitted. Revenue from the admission has not changed, so cost reductions benefit the hospital. To encourage doctors to manage care more effectively, a portion of the cost-reduction is provided to the physician of record, which is the attending physician for medical cases or surgeon for surgical cases.

Shared savings programs are riskier than gainsharing programs because they are based on decreasing service utilization, which reduces revenue. *Kaiser Health News* in 2014 reported that one-quarter of ACOs earned bonus pay. But the National Associa-

SNAPSHOT

Successful shared savings and gainsharing programs are based on controlling costs. But incentives are structured and distributed in different ways, and they require separate strategies for physician alignment.

IMAGE BY BRUNO BUDROVIC/ILLUSTRATION SOURCE

tion of ACOs found that two-thirds of Medicare Shared Savings Program ACOs are either highly unlikely or unlikely to remain in the ACO program. While there are proposals to relax rules to meet the Centers for Medicare & Medicaid Services' goal of having one-half of all Medicare spending under accountable care and other new payment models by 2018, the American Hospital Association in a February letter to CMS questioned whether the proposal will go far enough to fix elements that emphasize penalties rather than rewards.

Gainsharing, conversely, carries little risk because physicians are provided a share of the inpatient cost savings only if they are realized. In an analysis of a gainsharing program in New Jersey, published in the *Physician Executive Journal of Medical Management,* most hospitals were able to show significant savings in the cost of care.

Another difference is in the physician strategy. Because shared savings is focused on reducing utilization, success will be achieved by developing an effective primary care strategy that focuses on preventive services and managing population health. With gainsharing, the focus is on inpatient cost, which will affect all physicians, including hospitalists, surgeons and specialists.

2. Participation Options

CMS states that hospitals' implementing all bundled payment models also can participate in gainsharing, and it allows hospitals that are adopting a gainsharing program to participate in shared savings programs.

The reasoning is that although an ACO's goal is to reduce health care expenditures for a population and direct patients to appropriate, lower-cost settings, some patients still will need inpatient care, and hospitals should encourage physicians to deliver it in the most cost-effective manner.

Gainsharing complements shared savings programs by lowering acute care costs at the case level. In fact, it is foundational to shared savings programs, and provides hospitals with the competencies to manage an increase in contractual relationships, information sharing and care coordination, according to a May 2014 article in *HFM Journal.*

3. Incentive Distribution

Shared savings and gainsharing programs distribute incentives in different ways. In shared savings, the payer distributes the incentive to the ACO participants based on agreed-upon formulas using as a basis the amount of money that the payer saved in delivering services. The payer benefits from the majority of the savings and pays hospitals a portion, followed by physicians and other providers. As health care practices change, the savings to be shared diminish over time because improvements are calculated each year. In other words, once the behavior is changed, the goal is achieved.

In gainsharing, hospitals distribute a portion of their cost reductions to participating physicians, subject to upper limit amounts that are either established by CMS or based on a fair market value analysis in commercial applications as appropriate. Initially, the hospital benefits most from the cost reductions, but the participating physicians get rewarded for reducing

Shared Savings vs. Gainsharing: Incentive Distribution

ELEMENTS	SHARED SAVINGS	GAINSHARING
Compensation calculations	Complex. Requires an algorithm for allocating payer savings among multiple providers. Creating a new legal entity to calculate and distribute incentives often is required.	Simple. Per unit savings are determined based on best practice and physician improvement. Incentives can be made to existing physician practice models, whether they are employed, group practice or solo practitioners.
Timing of incentive payments (post-implementation)	Annual. Initial payments may take 18 months to two years due to calculations of resources used; subsequent payments are annual.	Biannual. Initial payments are provided nine months after program starts and every six months thereafter.
Payer	Payer sees majority of savings when fewer resources are utilized.	Payers may see long-term benefits as hospital cost reductions could lower the rate of increase over time.
Provider	A portion of the payer's savings are distributed to participating providers.	When resource utilization becomes more efficient, providers' costs decrease and cost reductions are basis for payments made to participating physicians.

Source: Applied Medical Software, 2015

Shared Savings vs. Gainsharing: Success Factors

ENTITY	SHARED SAVINGS	GAINSHARING
Payer	Offers incentives to providers to move patients to lower-cost, higher-value services.	Decreasing hospital costs creates a basis for lower future payment rates. Insurer may require a discount in payment for hospitals participating in the program if the insurer sponsors the program.
Hospital or health system	Hospital patient revenue will decline by decreasing utilization of acute care services. The hospital makes up a portion of the declining patient revenue loss by receiving a portion of the payer's overall savings in caring for the population at risk.	Hospitals decrease costs per case, and thus improve financial performance per case. Gainsharing does not impact hospital revenue.
Physician	Physicians lose revenue by decreasing utilization of services. Physicians make up a portion of declining patient revenue by receiving a portion of the payer's overall savings in caring for the population at risk.	Physicians gain an additional revenue stream by receiving an incentive payment from the hospital based on cost reductions. This offsets physician loss of income from decreased per diem billings.

Source: Applied Medical Software, 2015

costs and for maintaining improved performance, so payments continue even as marginal hospital cost reductions become less significant.

The timing of incentive distribution is constrained by the data collection and analysis. For shared savings, the savings are based on annual payment data, given time to receive, analyze and verify the data. Distribution of incentives is around 18–24 months after the program begins. Gainsharing results may be distributed semiannually. Because standard billing data are used, incentives are distributed nine months after the program begins, and then every six months afterward. The speed and frequency of gainsharing payments are more likely to engage physicians and encourage the desired behavioral changes, which in turn helps both a stand-alone gainsharing program or one that is part of a shared savings initiative [see Shared Savings vs. Gainsharing: Incentive Distribution, Page 20].

4. Requirements for Success

Both shared savings and gainsharing require physician alignment. The medical staff have to be partners for the programs to succeed.

As risk increases and hospitals move from gainsharing programs to include ACOs or bundled payments, management structures become more sophisticated. On its own, gainsharing provides the system for measuring and rewarding inpatient performance. When implemented with shared savings structures, gainsharing aligns incentives, making success more likely.

Provider success in shared savings programs depends on negotiating favorable terms with the payer to share a portion of the savings [see Shared Savings vs. Gainsharing: Success Factors, this page]. These payments compensate decreasing hospital or system revenue. In contrast, success in gainsharing programs requires reducing the service cost with no change in payment.

Powerful Tools

Shared savings are realized by managing population health. In general, the programs focus on reducing payments at the population level by payers, while gainsharing programs focus on reducing cost — not payment — on an individual case. Shared savings programs can fail if hospitals reduce revenue by delivering care in appropriate, lower-cost settings without effectively managing inpatient costs. Gainsharing is the conduit to lower the actual cost of care generated by aligning incentives with physicians who deliver that care.

Both programs aim to increase health care value by lowering costs and improving patient outcomes and experience. While they both allow for sharing accountability for care, gainsharing focuses on cost savings as the basis for incentives, while shared savings allocates a portion of reduced payments from the insurers. Because cost control is required in both circumstances for providers to succeed, gainsharing can be an effective foundation on which hospitals can build to succeed in shared savings programs. **T**

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