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By Paul Markovich

INNOVATION PROFILE

A Global Budget Pilot Project Among Provider Partners And Blue Shield Of California Led To Savings In First Two Years

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ABSTRACT Health care plans and providers in the private sector are developing alternative payment and delivery models to reduce spending and improve health care quality. To respond to intense competition from other organizations, Blue Shield of California created a partnership with health care providers to use an annual global budget for total expected spending and to share risk and savings among partners for providing health care. The patient population consisted of certain members of the California Public Employees' Retirement System in Northern California. Launched in 2010, the pilot accountable care organization in Sacramento provided a framework for operations and established goals and financial risk arrangements. The model shows early promise for its ease of implementation and effectiveness in controlling costs. During the two-year period, the total compound annual growth rate for per member per month cost was approximately 3 percent, or less than half the rate at which premiums rose over the past decade. Some of the savings stemmed from declines in inpatient lengths-of-stay and thirty-day readmission rates. Results suggest that the approach can achieve considerable financial savings in as little as one year and can gain wide acceptance from reform-minded providers.

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Public and private payers have made numerous attempts to alter the methods by which providers are paid, with the goal of creating incentives for providers to deliver health care more efficiently and effectively. Federal and state policy makers have focused their payment reform efforts primarily on Medicare and Medicaid.

However, alternative payment and delivery models are proliferating in the private sector to test how best to change the prevailing fee-for-service reimbursement method and get better value for dollars spent. These models include patient-centered medical homes, in which a per-

sonal physician coordinates a team of people to provide comprehensive and integrated care; bundled payments, which reimburse multiple providers for clinically defined episodes of care; and, more recently, accountable care organizations, which are alliances of physicians, hospitals, and other providers that agree to be accountable for the quality, cost, and overall care of a defined group of patients.

Blue Shield of California has adopted an approach to effectively aligning incentives among health plan and provider partners by using a global budget with shared risk layered atop existing payment mechanisms. This approach involves establishing a global per member per

month target amount for the cost of health care without changing the underlying payment mechanisms to physicians and hospitals.

The global target and shared risk among partners for achieving the target aligns incentives by giving all partners a financial stake in ensuring that expenses do not exceed the target. At the end of the year, if costs exceed that amount, the health plan, hospital, and physician group or individual physicians each write off those expenses. If expenses are below the target, the partners share in the savings.

To ensure financial integration, the partners agree to share savings as well as risks for each category of health care service within the per member per month target. This approach drives the clinical and technological integration needed to coordinate evidence-based care across care settings. It also provides a strong incentive to shed costs instead of shifting them from one provider to another or maximizing fees.

Blue Shield took this approach involving global payments and shared risks with its partners Dignity Health—formerly Catholic Healthcare West, the largest hospital system in California—and Hill Physicians Medical Group. Together, the partners launched a pilot accountable care organization in the greater Sacramento area in January 2010 for 41,000 California Public Employees' Retirement System (CalPERS) employees and dependents enrolled in a Blue Shield health maintenance organization.

Background

The main impetus for the pilot Sacramento accountable care organization was the need to address quickly the risk to the three partners' collective price for services and, by extension, market share. The partners collectively face strong competition from a more tightly integrated health system operating in the same market, Kaiser Permanente, which has 3.2 million members in Northern California alone.

The partners began talking about the collaboration in 2007 and signed an agreement in April 2009. Because all 41,000 members of the system that participated in the pilot accountable care organization are assigned to Hill Physicians Medical Group, and about 70–75 percent of their spending for services in health care facilities goes to Dignity Health, the parties had the critical mass that they needed to work together on the pilot organization.

Creating A Partnership

The first step was to establish mutual trust among the partners. For Blue Shield, this meant

convincing Dignity Health and Hill Physicians Medical Group that the health plan was genuinely interested in sharing risk, not merely shifting it. Blue Shield had a fee-for-service arrangement with Dignity Health's hospitals, and the medical group used a capitation payment methodology with Blue Shield. All of the partners were accustomed to bargaining fiercely with each other over what payment rates were acceptable, with no financial integration to control utilization.

Because of this radically new approach, it was imperative that senior leaders from each of the three partners were personally involved in the effort to forge the partnership. For the development of the accountable care organization, a governing board was created, consisting of executive leaders from each partner. Members of the board included executive leaders from each organization, including a CEO, chief operating officer, senior vice president of networking, and chief medical officer. The board formulated strategy, made key decisions about funding and contracting, and, at times, broke deadlocks among the partners.

Agreeing On An Integration Framework

Once the partners had established a common agenda, the next step was to formalize their alignment in a contract that provided a framework for tight clinical and financial integration. The agreement specified membership, cost of health care, and utilization goals.

To develop the agreement, the partners formed a "cost of health care" team whose members were drawn from across the breadth of the three organizations, including clinical operations, finance, data analytics, marketing, contracts, and legal—which had to ensure that the collaboration complied with all laws and regulations, including those related to antitrust and privacy. As shown in Exhibit 1, the team concentrated on initiatives related to the following five key strategies: to improve information exchange, coordinate processes such as discharge planning, eliminate unnecessary care, reduce variation in practice and resources, and reduce pharmacy costs.

These strategies emerged from an exhaustive review of the target population to identify who and what were driving costs. The review focused on chronically ill patients, especially the 5,000 who accounted for 75 percent of total health care costs in the population for the pilot accountable care organization. The partners also classified hospital cases to identify heavy users and to establish benchmarks for improved care.

EXHIBIT 1**Strategies And Sample Initiatives To Improve Quality And Reduce Costs In A Pilot Accountable Care Organization In California**

Strategy	Initiative
Facilitate the exchange of patient medical information through integrated electronic health information	Allow physicians to “push” electronic health records to hospitals with scheduling of patient admissions Build a tool on the Mobile MD platform to share clinical information
Reduce physician clinical and resource variation through quantitative analysis and targeted interventions	Reduce emergency department costs and use by shifting nonemergency visits to urgent care clinics or primary care providers Optimize outpatient surgery use and reimbursement; shift ambulatory surgery from partner facilities Develop programs to include preauthorization, clinical pathways, care planning, and adherence; educate and monitor physicians on accepted protocols
Manage utilization through coordinated operational infrastructure and clinical processes	Develop presurgical checklists for patient calls prior to procedures Build a process to identify, review, and correct causes of variation, providing opportunities to modify processes and change behaviors of physicians, hospitals, and support teams Coordinate pre- and postdischarge planning processes to avoid delays and readmissions Define and implement evidence-based guidelines (including those on the use of ineffective and marginal procedures) for surgeries in high-volume, high-cost hospital stays
Personalize care and disease management to eliminate unnecessary utilization and noncompliance with evidence-based care	Develop a comprehensive palliative care program across hospital, physicians, and care managers to engage patients and their families in end-of-life decisions Implement home-based medical care for high-risk, frail, elderly patients to improve their quality of life Identify centers of excellence in physical therapy so that chronic pain patients will learn new behaviors and explore underlying issues related to pain
Reduce pharmacy costs through directed member outreach, drug purchasing, and contracting strategies	Provide support to physician offices to implement processes and workflows that support oncology case rate methodologies to reduce injectable medication costs Increase use of generic medications through evaluation of primary care provider and specialist prescribing patterns

SOURCE Blue Shield of California.

The global per member per month target superseded the underlying capitation payment methodology for Hill Physicians Medical Group and the fee-for-service payment methodology for Dignity Health. All three partners assumed financial risk for meeting cost targets while maintaining or improving quality.

Goals For The Pilot Organization

The accountable care organization pilot had four goals. The first was to deliver cost savings and an immediate premium credit to CalPERS by reducing the growth in the cost of health care from 10 percent to 0 percent in the first year. The second was to grow the organization’s membership by attracting new public agencies to contract with CalPERS for health benefits and increasing enrollment for the partners in the pilot.

The third goal was to maintain or, if possible, improve the quality of health care provided by the three partners. According to the agreement signed by the partners, no cost containment initiative could be launched if it was expected to have a negative impact on quality. In addition,

several initiatives were designed to improve quality.

The fourth goal was to create a sustainable model for expansion to other geographic areas. In other words, the partners wanted to develop a model that would allow them to work together in the drive for continuous improvement in cost, quality, and service. The model needed to be financially sustainable for all three partners and to be applicable to other regions.

Sharing Financial Risk

As a result of the partners’ agreement to reduce the growth in the cost of health care to 0 percent in the first year, CalPERS received an immediate premium credit of \$15.5 million that came from all three partners, according to their agreement. The partners then had an urgent need to identify initiatives that would achieve savings.

Because all partners had both upside and downside financial risk for total health care expenditures, they had a powerful incentive to help each other. This imperative applied to all of the cost categories, which were divided as fol-

lows: facility costs, professional costs, mental health costs, pharmacy costs, and ancillary costs (Exhibit 2).

Each partner's degree of risk depended on its ability to influence per member per month costs in a particular category. As Exhibit 2 shows, Dignity Health carried more of the risk for facility costs; Hill Physicians Medical Group and Blue Shield assumed more risk for professional services; pharmacy cost risks were spread evenly across the partners; and Blue Shield assumed the greatest risk for ancillary services. In addition to developing the overall program structure and providing advanced analytics to help the accountable care organization coordinate care more effectively, Blue Shield oversaw information technology integration and provided guidance on legal issues.

The global budget approach is not a one-size-fits-all solution. The effectiveness of a global budget can be diluted in a broad network with no preassigned members—such as the current Medicare accountable care organization model. The reason is that a broad network greatly increases the complexity and number of provider relationships that need to be managed to effectively coordinate care. In addition, without preassigned members, it is difficult to perform the deep analyses necessary to understand a population's cost drivers and develop interventions based on clinical best practices to address those costs. A global budget is best suited for narrow networks with predefined populations.

First-Year Results

The first-year results of the pilot Sacramento accountable care organization have been positive. Blue Shield of California engaged Milliman, an actuarial and consulting firm, to conduct a

rigorous analysis of the pilot organization's costs and savings in 2010, its first year of operation. Milliman concluded that the pilot program savings were \$15.5 million, with per member costs 10 percent lower than those for Northern California CalPERS members not in the pilot.¹

Health care costs for CalPERS members in the pilot accountable care organization were \$393.08 per person per month in 2010, a 1.6 percent decrease from the 2009 baseline amount. For members not in the organization, costs were \$435.94 per person per month, which was a 9.9 percent increase from 2009 for that group.

Half of the savings for the accountable care organization population came from reductions in health care resource use. The remainder came from slowing the rate of increase in unit cost reimbursement.

Milliman found that inpatient days for CalPERS members in the accountable care organization fell from 9,697 days in 2009 to 8,520 days in 2010—a decrease of 12.1 percent. At the same time, the number of members increased by about 2.5 percent from 2009 to 2010, meaning that the number of days spent in hospital per thousand members declined by about 15 percent.

Hospital days were also down for Blue Shield's members in the Sacramento area who were not in the accountable care organization, and for members statewide. However, those declines were only 5.9 percent and 4.9 percent, respectively.

In addition, hospital readmissions within thirty days of discharge for the CalPERS members in the accountable care organization also fell 15 percent, from an already low 5.4 percent of cases to 4.3 percent. And Blue Shield data showed that extended hospital stays—those of twenty days or longer—fell by 50 percent. Some

EXHIBIT 2

Allocation Of Risk For Three Partners In A Pilot Accountable Care Organization In California

Cost category	Per member per month target cost	Allocation of risk if actual costs fall above or below target cost		
		Dignity Health	Hill Physicians Medical Group	Blue Shield
Total facility				
Partner hospital	\$180	50.0%	25.0%	25.0%
Out-of-area nonpartner hospital	25	25.0	25.0	50.0
Other nonpartner hospital	45	30.0	30.0	40.0
Professional	125	30.0	35.0	35.0
Mental health	10	0.0	0.0	100.0
Pharmacy	55	33.3	33.3	33.3
Ancillary	10	25.0	25.0	50.0

SOURCE Blue Shield of California. NOTES Total facility target cost is \$250. Total target cost is \$450.

of this decline appears to be random variation, however, because large claims for such extended hospital stays appear to have risen to a more normal level in 2011.

Most of the first-year savings from lower utilization could be attributed to reducing the average length-of-stay. According to Milliman, the pilot accountable care organization “experienced a larger reduction in inpatient length of stay than other areas in Northern California.”^{1(p5)} However, Milliman found an unexplained increase in emergency department utilization for CalPERS members in the pilot organization, something the three partners have sought to manage through interventions such as shifting nonurgent emergency department visits to care clinics.

Milliman’s analysis confirmed the partners’ belief that data sharing was key to their success in reducing the escalation of costs and premiums: “By sharing data, the three partner organizations have been able to identify where costs were unnecessarily high and implement solutions to bring those costs down. These insights would not have been possible without the collaboration required under the accountable care organization model.”^{1(p6)}

Overutilization, preventable readmissions, and out-of-network services were identified as the three areas ripest for bringing costs down further. For example, overuse of elective surgeries drove costs higher. “Hysterectomies and elective knee surgeries were revealed to be the biggest cost drivers,” noted Milliman.^{1(p6)} Costs and variation from evidence-based approaches for bariatric surgery for weight loss also stood out.

The accountable care organization saved CalPERS \$15.5 million through the immediate premium credit delivered in 2010, and the three partners shared an additional \$5 million in savings that were realized by managing to keep health care expenses below the budgeted target. This was in accordance with the global budget and risk share agreement.

Second-Year Results

The pilot organization continued to show positive results in its second year. For the two-year period 2010–11, it delivered \$37 million in savings to CalPERS, based on the growth in the cost of health care in the pilot compared to what that growth would have been without the pilot in place. The partners beat the 2011 cost of health care target by \$8 million, which was shared by the partners according to their agreement.

The thirty-day readmission rate continued to decline, from 4.3 percent in 2010 to 4.1 percent

in 2011. Average length-of-stay, which decreased from 4.05 days in 2009 to 3.53 in 2010, increased to 3.74 in 2011 because of a considerable increase in catastrophic cases. But it remained below 2009 levels and was well below that of Northern California CalPERS members who were not in the pilot accountable care organization.

During the two-year period, the compound annual growth rate for per member per month cost was approximately 3 percent, which was markedly lower than the increase Blue Shield experienced elsewhere in the region and state. That level of increase—projected to remain roughly the same for 2012—is less than half the rate at which premiums rose over the past decade, as health care costs increased unsustainably and those costs were increasingly shifted to private payers.

Discussion

The global budget approach has worked for the pilot accountable care organization for four main reasons. The approach effectively aligned incentives, was easy to implement, enabled rapid identification of opportunities to deliver cost and quality improvements, and established incentives to achieve short-term process improvements and keep patients healthy over the long term.

ALIGNED INCENTIVES In developing the pilot accountable care organization, the three partners sought to address shortcomings in the existing reimbursement structure. Specifically, they sought to reward efficiency and quality rather than quantity. Although cost growth needed to be restrained, simply reducing provider reimbursements was not a sustainable long-term approach because it would not provide the financial incentive needed for all of the partners to coordinate care more efficiently.

Health plan and employer incentives generally affect one component of health care delivery without reinforcing a long-term, systemwide approach. For example, benefit changes affect member cost and behavior but don’t address the lack of coordination between providers and the health plan. In addition, incentives that health plans give to providers do not generally reward hospitals for being more efficient. The existing reimbursement structure provided no incentives for the three partners—a health plan, a hospital, and a medical group—to work together to improve care delivery.

The global budget and risk sharing elements of the pilot accountable care organization created financial alignment and ensured that all partners would pursue only those care delivery and cost containment strategies that were tied directly to

agreed-on metrics for membership, cost of health care, and utilization while maintaining or improving quality.

This arrangement provided a powerful way to tie providers directly to the premium that the customer (in this case, CalPERS) pays and to see how the price they charge compares to that of the competition (Kaiser Permanente). Largely because of the risk sharing agreement and the partners' commitment to working together, the pilot program turned a traditional adversarial relationship into a model in which everyone was on the same side.

EASY IMPLEMENTATION A macro-level budget approach can be deployed quickly because it is a simple approach to introduce. There is no change in day-to-day reimbursement levels, and therefore there is no need to perform complicated analytics to understand whether the new payment method is budget-neutral. Once the partners determined how to work together and decided on the global budget approach, it took less than three months to agree on the details for global budgets and risk sharing.

An alternative approach that other groups have adopted is payment bundling. This is a very complex undertaking, as is shown by the years required to address administrative, technical, and communication challenges by the providers and payers participating in the PROMOTHEUS payment program, an initiative of the Health Care Incentives Improvement Institute.² Any bundled payment approach involves defining the bundle of services to be covered; developing new contracts; retooling information systems; training staff members to bill, disburse, and collect payments; developing the actuarial and financial skills necessary to figure out how to split the payment into its appropriate pieces; and tracking and managing costs.

EASILY IDENTIFIED IMPROVEMENTS The global budget approach facilitates a high-level perspective and lets partners quickly identify clinical and cost "hot spots" where opportunities exist for the greatest improvement. Partners can then agree on what changes to make and can create value by reengineering the clinical process.

For instance, the three partners in the pilot accountable care organization spent considerable effort developing a new integrated discharge planning process that was instrumental in reducing readmissions in the first year of the organization. Key elements of the new process included creating a summary of the essential medical issues in each case within forty-eight hours of admission and conducting a post-discharge needs assessment.

The new process also included analyzing the clinical course and major events of the hospitali-

zation; integrating lab results into confirmations of diagnoses; and identifying principal and relevant secondary clinical diagnoses on discharge. And the new process involved medication reconciliation to check for errors and interactions and a component that ensured that follow-up appointments were scheduled within appropriate periods.

The partners also redesigned the patient education process to improve patient and family or caregiver understanding of the discharge plan and self-care requirements. Patients were provided with a discharge plan written in nontechnical language. That discharge plan was also forwarded to the patient's medical group.

ESTABLISHED INCENTIVES One problem with solutions like bundled payments is that they pay providers to care for patients who are already ill. In contrast, a global budget model with risk sharing encourages all parties to keep patients healthy, use clinical interventions only when necessary, and work closely together to ensure that patients receive the most appropriate and timely care.

It takes more than a few years to achieve cost savings by sustainably improving the health of a population. Although these savings are essential to the long-term success of this global budget approach, the three partners achieved shorter-term success by identifying changes they could make to administrative and clinical processes to streamline care and reduce unnecessary utilization by patients. The fact that CalPERS received an immediate premium credit from the partners according to their risk sharing agreement provided a powerful incentive for them to collaborate to deliver cost savings.

EXPANDING THE GLOBAL BUDGET APPROACH The pilot accountable care organization has attracted national attention. On a visit to Dignity Health's Saint Francis Memorial Hospital in San Francisco on September 16, 2011, health and human services secretary Kathleen Sebelius was briefed on the partners' collaboration. At that event, she said, "This program is on our radar screen as one of the best examples of patient care in the country, and the kind of care that people elsewhere hope to enjoy in the future."³

The global budget model is showing promise elsewhere, too. Researchers from Harvard Medical School studied the first two years of data from Blue Cross Blue Shield of Massachusetts's Alternative Quality Contract, that health plan's global budget program. The researchers found that the program slowed the underlying growth in medical spending and improved quality of care, compared to control groups, by shifting procedures to facilities that charged lower fees; reducing utilization among some groups of patients;

and delivering improvements in chronic care management, adult preventive care, and pediatric care.⁴

As shown in the online Appendix,⁵ Blue Shield of California is applying the global budget approach in a total of eight accountable care organizations serving 130,000 members across California. The aim is to establish at least twenty accountable care organizations by 2015. In addition, to strengthen the model, the three partners are adding quality and efficiency incentives, and patient satisfaction goals and measures are under development.

Conclusion

The partners' experience to date suggests that a global budget approach can gain wide acceptance from reform-minded providers eager to make changes that can yield savings and improvements in clinical care. At the same time, providers may be wary of what a completely new payment method would mean for them. Blue Shield now has eight accountable care organizations across California that use global budgets and has received requests to establish more than a dozen other such organizations.

A global budget aligns incentives effectively, is easier to implement than bundled payments, en-

ables the participants to immediately focus on improving care delivery, and rewards providers if patients stay healthy. For all of these reasons, it also has the potential to be quickly expanded.

A large majority of Americans do not have ready access to fully integrated networks such as Kaiser Permanente, Mayo Clinic, or Geisinger Health System. Integration like that of the three partners in the pilot accountable care organization described here is one way to provide improved, more tightly coordinated, and more effective care in markets lacking such networks.

Working with a variety of provider partners, Blue Shield of California is demonstrating how this risk sharing model improves care delivery by aligning physicians and hospitals with the payer. The rapid early expansion of this approach suggests that the model is replicable and easy to expand.

After decades of unchecked growth in health care costs and difficulty in trying to rid the payment system of perverse incentives, this model provides an example of a system that brings providers and payers together to share the savings from better coordinated care, and to pay a price if there are no savings. This innovative model may help Americans get the care they need at a price they can afford. ■

This article is an enhancement of a presentation delivered at America's Health Insurance Plans' Summit on Shared Accountability, Washington, D.C., October 18, 2011. *Health Affairs* was a media partner for this event.

NOTES

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- 5 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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Paul Markovich is president and chief operating officer of Blue Shield of California.

In this month's *Health Affairs*, Paul Markovich, president and chief operating officer of Blue Shield of California, reports on a partnership that his organization created in 2010 with local providers to provide care for certain members of the California Public Employees' Retirement System in Northern California. Based on an annual global budget for total expected spending, and with shared risk and savings among the partners,

adoption of the model has so far resulted in considerable financial savings from such factors as declines in inpatient lengths-of-stay.

At Blue Shield of California, a 3.3 million member not-for-profit health plan that serves the commercial, individual, and government markets, Markovich oversees health care services, network management, e-business, marketing, product development, customer operations, and all three of Blue Shield's business units that offer medical and specialty benefits coverage. He was appointed president of Blue Shield and a member of its board of directors in June 2012, and he will assume the position of CEO in January 2013.

This is Markovich's second tour of duty with Blue Shield. In the late

1990s he led the company's product development unit, and he introduced such products and services as the first California health maintenance organization to allow self-referrals to specialists. He went on to found a consumer-driven health plan, mywayhealth.com, and joined Definity Health, a consumer-driven health plan based in Minneapolis, before returning to Blue Shield of California.

Markovich has a bachelor of arts degree in international political economics from Colorado College and was a Rhodes Scholar. He serves on the board of directors of the Bay Area Council and the California Association of Health Plans.