

# Promote Adoption of Population-Based Provider Payment

Cost Driver Targeted: Global spending

## OVERVIEW

Transitioning health care provider payment from fee-for-service to value-based payments (VBPs) tied to the quality of care provided has gained interest during the past decade. A population-based payment is a type of VBP that pays for a set of services for an individual's care during a given period or for a specific condition.

The Healthcare Payment Learning and Action Network has categorized different types of [value-based payment models](#), with population-based payments identified as the most advanced. Population-based payment models emphasize three features: they are prospective, based on a budget, and require providers to take on risk for costs of care that exceed the budgeted amount. Population-based payments give providers more flexibility to coordinate and optimally manage care for individuals and populations. These models also may incentivize providers to develop more innovative approaches to person-centered health care delivery by rewarding those that successfully manage care.

However, moving health care toward a population-based payment system is challenging. Population-based payment models require providers to fundamentally change the way they provide care, and these changes are not sustainable unless a critical mass of public and private payers adopt aligned approaches. These models also require provider organizations to take on greater financial risk than they have assumed under the traditional, fee-for-service payment system, a move that not all providers are prepared to make.

Several states have pursued strategies to move toward population-based payments across their health care markets. Although no state has moved fully into prospective, population-based payments, efforts to move along the continuum toward more advanced value-based payment models provide some lessons for interested states.

## KEY STEPS IN DESIGN AND IMPLEMENTATION

**Identify the payment model to be advanced.** States can start by identifying the type of model or models they wish to promote. Rhode Island, for example, included a specific requirement for prospective payment for primary care. Some states, such as Arkansas and Ohio, have focused on episode-based payments, which could potentially become the foundation for population-based payments for certain conditions. Maryland has a unique model that includes a global (though not prospective) budget for hospitals, an approach that Pennsylvania also has adopted for its rural hospitals. Oregon doesn't focus on one specific model but rather has benchmarks organized around the Healthcare Payment Learning and Action Network's framework for alternative payment methodologies, which shifts provider payments into advanced models that involve more risk sharing.

**Determine whether to use a voluntary or mandatory approach.** Several states have taken voluntary approaches to promote population-based payments in the commercial market. When Arkansas developed episode-based payments in its Medicaid program, two of its largest commercial payers aligned their own payment methodologies. More recently, Ohio has convened commercial plans and the Medicaid agency to collaborate on a multipayer delivery system reform initiative that includes comprehensive primary care payment and episode-based payments. Oregon, which has pursued value-based payment in its Medicaid program, developed a voluntary compact to galvanize momentum toward value-based payment within the commercial market. More than 40 health care organizations [signed the compact](#) and committed to making a good faith effort to “participate in and spread” VBPs. They also committed to move from having 35 percent of payments under advanced VBP models in 2021 to having 70 percent of payments be value-based by 2024.

Other states have adopted a mandatory approach using regulatory or statutory requirements. In 2020, Rhode Island's Office of the Health Insurance Commissioner established [affordability standards](#) that require insurers to increase their use of alternative payment methods. They also specifically require insurers to adopt a prospective payment model for primary care, with payments through

these models accounting for 60 percent of covered lives by January 2024. In 2021, [Delaware enacted a law](#) that requires the state's Office of Value-Based Health Care Delivery to establish requirements for adopting innovative payment models.

In weighing whether to take a voluntary or mandatory approach, states may want to consider that legislation provides durable authority but will require navigating a legislative process. States also may plan for enforcement activities to make the legislation meaningful. In comparison, a voluntary approach emphasizes a collaborative, market-driven strategy, which can hold political appeal but does not enable enforcement.

**Establish oversight for the initiative.** Monitoring whether entities are meeting their goals is important for the success of these payment models. For states pursuing a mandatory approach, that oversight has fallen to the state insurance department, which has the ability to regulate insurance providers. In Rhode Island, the Office of the Health Insurance Commissioner oversees the requirement for prospective payments. In Delaware's legislation, responsibility for designing and overseeing the requirement for adopting payment innovations rests with the Office of Value-Based Health Care Delivery. Oregon's compact, which is voluntary, is overseen by a workgroup that is jointly convened by a governmental agency (the Oregon Health Authority) and the Oregon Health Leadership Council, a stakeholder body with leaders from health care organizations across the state.

## EVIDENCE OF IMPACT

Evidence for cost savings with population-based payments is limited, though the evidence that fee-for-service payment drives spending through increased volume and intensity of services is strong. Most research has focused on evaluation of accountable care organization (ACO) models, which have some but not all of the features of population-based payment.

The Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts' ACO program, has been shown to [improve quality and lead to savings](#). It is one of the only large-scale evaluations in the commercial market to date, although it initially involved HMO enrollees only.

In Medicare's Shared Savings Program, physician-led ACOs (compared with hospital-integrated ACOs) achieved **modest savings in total spending**. The **Next Generation ACO** program, which had more significant risk sharing, decreased Medicare Parts A and B spending by \$348.6 million relative to the comparison group, although this savings was offset by \$466.1 million in shared savings and beneficiary incentives.

**Maryland's global budget** for hospitals was found to slow total expenditure growth for Medicare beneficiaries by 2.8 percent relative to the comparison group, largely driven by 4.1 percent slower growth in total hospital expenditures. Commercial plan members had 6.1 percent slower growth in total hospital expenditures relative to a comparison group; however, growth in total expenditures did not abate.

## IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

The Center for Medicare and Medicaid Innovation has a strong interest in partnering with states on new payment models, potentially creating new momentum for states to engage in this arena. A population-based payment strategy is likely most attractive to states with the following features:

- A delivery system landscape that is prepared to accept population-based payments. To be successful, providers need the infrastructure (people, technology, data, and processes) to facilitate care coordination, improve clinical care delivery, and track clinical and financial performance. The state can help providers by reducing barriers to payer adoption (e.g., aligning performance measures across insurers), considering infrastructure investments (e.g., health information exchange), and supporting learning collaboratives.
- The analytic capacity to define the payment model, solve for technical implementation issues (e.g., how patients are attributed to providers), and monitor uptake.
- If a voluntary approach is being considered for the commercial market, payer and provider partners who will support this effort on a sustained basis.

Population-based payment is a strategy with wide appeal and application across states, though states with stronger market orientations will likely shy away from mandatory approaches.

## EQUITY CONSIDERATIONS

Alternative payment models such as population-based payments could potentially worsen health disparities in a number of ways. One concern is that they “bake in” historical disparities in access to care and utilization, resulting in baseline assumptions that could be predicated on underutilization. Another concern is that provider organizations might be inclined to pursue patients with fewer socioeconomic challenges. There also have been concerns raised about disparities in geographic access if ACOs are less likely to form in underserved areas and about the impact of financial penalties on safety-net providers.

Research has explored the extent to which these issues occur in current alternative payment models. Several descriptive, **cross-sectional analyses** suggest that **disparities in geographic access** may exist under Medicare ACOs, which are less likely to form in higher poverty areas with more racial minorities and poorly educated individuals, compared with more affluent areas. However, evidence is more mixed about whether providers in existing ACOs exacerbate disparities by selecting lower-complexity or less vulnerable patients. **Some studies** found that ACO-attributed patients were more likely to come from vulnerable populations while **other studies** suggested that patients with higher clinical risk scores were more likely to exit an ACO program.

To address concerns, researchers have **identified certain strategies** — such as assessing improvement (not just performance) and strengthening risk-adjustment models — that could help mitigate some of these impacts. Some programs also have set up initiatives to support providers caring for socioeconomically disadvantaged populations, such as the now-defunct **Accountable Care Organization Investment Model (AIM)**, which provided up-front and ongoing monthly payments to smaller providers in rural and underserved areas to enter the Medicare Shared Savings Program. Looking ahead, the Center for Medicare and Medicaid Innovation has identified equity as a top priority in its development of future models.

## OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

ACOs could potentially incentivize consolidation of physician groups, with some studies finding an [increase in large practices](#) in areas with the greatest ACO penetration. Even short of consolidation, there is concern that ACOs could lead to price increases if participants jointly negotiate prices.

From a consumer perspective, population-based payments raise concern about stinting or undertreatment. Evaluating quality of care is one strategy to protect against stinting, but quality measures are not able to assess every aspect of care. Strong oversight mechanisms and consumer protections are therefore vitally important components of population-based payment programs.

## RESOURCE

Caroline Picher et al., [State-Driven Initiatives to Support Moving to Value-Based Care in the Era of COVID-19](#) (National Governors Association Center for Best Practices and Duke-Margolis Center for Health Policy, Mar. 2021).