The Evolution of Reimbursement from Volume to Value: How does primary care succeed in this environment of uncertainty?

Focus Paper

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Re-Submitted October 5, 2016

This outline is being submitted to the American College of Medical Practice Executives in partial fulfillment of the requirements for election to Fellow.
Introduction

Health care executives are facing an unprecedented time of change and uncertainty. Success in the health care industry today requires an innovative and collaborative approach. Nationwide, governmental and commercial insurers expect providers to manage the health of a population, deliver community based care, and comply with payment models that use sophisticated methods of patient attribution to providers associated with the care of individuals. These changes are disrupting the current measures of success for providers and are driving innovation in the way care is delivered. Today, reimbursement is linked to the quality of specific clinical outcomes, resource utilization, patient satisfaction and access to care. Traditional fee-for-service and volume measures, e.g., office and hospital visits, hospital charges for inpatient stays and traditional ancillary services are changing. Health care providers, including physicians and other patient providers as well as health care facilities such as hospitals and outpatient centers must change from volume based models to also include care delivery models that improve quality outcomes and reduce costs. The complex nature of care requires strategic partnerships across the continuum of care within a community. Strategic alignment decisions being derived from big data and coordinating care for large populations can make a medical practice executive’s head spin!

This paper focuses upon the rapid change in the reimbursement environment from volume (services provided) to value (quality of outcomes / resource utilization), specifically as it pertains to the opportunity for primary care providers to significantly impact the drivers of quality outcomes and resource utilization. The current care delivery models are still geared to maximize volume of services although there is an increasing emphasis on providing high quality of care and
achieving superior clinical outcomes while simultaneously reducing costs. Clearly, the market is demanding better value and shifting the reimbursement model to reward high value providers. Primary care providers who successfully navigate rapid transformational change will thrive in the new pay for value environment. Also included in this paper is a review of the drivers of the change and a discussion regarding a sense of urgency for those who are prepared to seize the moment. Medical practices that are successful in navigating the new value based requirements will be financially rewarded for the superior value delivered to their patients as well as the population they serve.

A review of trade journal articles, executive interviews and a survey of health care leaders (non-clinical executives and physician executives) will provide insights about not only successfully navigating the challenges in this ever changing environment but also implementing solutions that support the new efforts toward improved quality of care, clinical outcomes and lower resource utilization. This paper will explore how primary care providers not only survive in the new health care paradigm but also become the leaders in managing the health of populations and delivering value.

**Historical perspective of significant health care legislation**

As the discussion about the current health care environment unfolds, it is informative to first review some of the more significant legislation that has occurred since the inception of Medicare and Medicaid in 1965. United States health care legislation dates back to the 1700’s (“A Historical Look”). However, the 1965 law that established the Medicare and Medicaid insurance program, which was signed by President Lyndon Johnson was the landmark event for the health care industry in modern times. Medicare initiated health care coverage for anyone 65 or older. Additionally, Medicaid, initiated health care coverage for the poor and disabled. This legislation
forever altered the health care industry of the United States. Since 1965 there have been numerous additional health care laws, the most significant and relevant to this paper, are detailed below from the Boston.com website article titled, ‘A historical look at health care legislation’. All of this legislation represents a continued effort on the part of the federal government to change the course of the health care industry, transform care delivery and make care available to all.

- 1985: Consolidated Omnibus Budget Reconciliation Act (COBRA) – This allows for the portability of health care coverage beyond the employment relationship. Additionally, hospice care is now a Medicare and Medicaid benefit.
- 1996: The Health Insurance Portability and Accountability Act (HIPAA) – This addressed the need for the protection of health information for all patients, who are now assured of the confidentiality of their protected health information (PHI).
- 1997:
  - The State Children’s Health Insurance Program (CHIP) – This provides health care coverage for low-income families that do not qualify for Medicaid.
  - Medicare Sustainable Growth Rate (SGR) formula enacted – This was an effort by Medicare to control costs by capping the annual increase to the physician fee schedule at a rate that is no greater than the corresponding annual Gross Domestic Product (GDP).
- 2010: Patient Protection and Affordable Care Act (PPACA), otherwise known as The Affordable Care Act (ACA) – This law represents the most comprehensive changes in health care since the inception of Medicare and Medicaid in 1965 and is also extremely complex. For purposes of this paper, the most relevant part of ACA is that it requires most people in the
United States to have health insurance coverage or face financial penalties. The law also requires employers to offer health care coverage or face financial penalties (Obamacare).

- **2015: Medicare Access & CHIP Reauthorization Act (MACRA) –** This legislation repealed the sustainable growth rate (SGR) methodology for determining updates to the Medicare physician fee schedule and establishes annual fee adjustments. This put an end to the annual discussion of, ‘Will the physicians see a 21% reduction in their reimbursement this year?’ which occurred seventeen times over a 13 year period. MACRA also establishes two ‘new’ incentive programs for physician payments. The first one is the Merit-based Incentive Payment System (MIPS), which is not really new but is more of a consolidation of three existing quality reporting programs: 1) Physician Quality Reporting System (PQRS), 2) Meaningful Use (MU) and 3) Value Based Modifier (VBM). The second incentive program is the Alternative Payment Model (APM), which rewards medical practices for participation in more complex arrangements such as certification as a Patient Centered Medical Home (PCMH), or for participation in an Accountable Care Organization (ACO), or a shared risk arrangement. (“MACRA slide deck”)

**Impact of the legislation**

From the above legislative regulations including COBRA, the McKinney Act, CHIP, the ACA and HIPAA, the goals of the Centers for Medicare and Medicaid Services (CMS) are clear. CMS wants to assure that as many people as practically possible have health care insurance coverage and have access to quality care at reduced costs with confidence that their PHI is secure as well as portable. It is also clear that through MACRA particularly the APM, CMS is encouraging participation in risk sharing arrangements where the focus is on collaboration across the continuum of care. Anyone that participates in an APM is exempt from MIPS, receives a 5% bonus and benefits from a slightly, 0.5%, higher fee schedule beginning 2026. Aside from the
onerous reporting of the combined quality information of PQRS, MU and VBPM, MIPS carries with it the possibility of a 4% penalty and the program must be budget neutral so there are risks for all that choose this option.

One of the primary care physicians surveyed for this paper added practical context to the impact of the legislative changes, some of which include efforts to improve quality of care and reduce costs over many years.

“As a primary care physician and health care executive, I have experienced value based payments for nearly 30 years. It’s taken various forms and names and started in the late 1980’s with a few insurers implementing Health Maintenance Organization (HMO) plans that contained primary care payments based upon fixed capitation rates for a portion of their subscriber base. HMO capitation plans largely began with an emphasis upon cutting costs and reducing utilization, particularly for inpatient and specialty care. There were a few basic quality metrics, e.g. childhood immunizations. However, the emphasis was clearly geared to force primary care physicians to become gatekeepers.

In the 1990’s, the model moved away from HMO capitation toward reduced fee-for-service rates but there was multiple at-risk quality withhold incentives. Only the provider groups who were able to provide high quality, efficient care were financially rewarded.

In the 2000’s, employers, particularly large self-insured employers, began to exert pressure upon providers to reduce costs and improve quality. The employers who had access to their own health care cost data were able to move the market toward providers who provided high quality, low cost care.
In the 2010’s, I was a leader in a shared risk arrangement between a large employer and health system. It was this arrangement that helped drive innovation toward an emphasis upon patient centered care, coordination of care across the continuum and development of a team based approach to populations of people for whom we were responsible, not simply patients who came to the office.”

It is also evident from the most recent legislative changes of 2010 and 2015, ACA and MACRA respectively, that CMS is making every effort to exert downward pressure on reimbursement to influence health care providers to change their health care delivery strategies so that the CMS goals of access to quality, cost effective care for all health insurance beneficiaries are met. Health care leaders cannot overestimate the impact of the historic repeal of the Sustainable Growth Rate (SGR) in 2015 through MACRA. Originally enacted in 2002, the repeal of SGR eliminated thirteen years of annual angst over the potential 20+% reduction in the Physician Fee Schedule (PFS). All health care leaders, particularly in the ambulatory environment, celebrated this repeal. However, there is a caveat that will have an impact on physician reimbursement as early as 2016 – this year! As part of MACRA, CMS issued a ruling that in addition to the physician fee schedule (PFS), 2016 payments to physicians would include a quality / cost component totaling 30% of reimbursement, which was based on services provided in 2014. So, essentially your homework is already turned in with no ability to influence the score and that is just the beginning. By 2018, 50% of reimbursement will be linked to quality outcomes and cost and will be based on services provided in 2016, which represents another two-year retrospective performance review. By 2020, 85% of payments will be tied to quality / cost, based upon services provided in 2018 (“MACRA slide deck”). “All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success. Providers must make fundamental changes in their day-to-day operations that improve the quality and reduce the cost
of health care” (Damrauer 10-13). Given the significant percentage of at-risk reimbursement and pace of escalation of these percentages, the question is why is the health care industry so slow to change? Where is the sense of urgency?

The pace of change – a sense of urgency

As part of the research for this paper, surveys and interviews of both physician leaders and non-physician leaders were conducted to understand their thoughts and motivations in this time of disruptive innovation. Comments from two practicing primary care physicians who also serve as physician leaders and a non-clinical leader provide some insight into why there is a lack of a sense of urgency.

“Unstable political environment for all of us. In our area of the country we still get paid for doing more; specialists and proceduralists are still highly compensated for volume; our health system is very hospital centric and moving to the idea of ambulatory care kicking and screaming so resources for value base ambulatory care are lacking until we start seeing payment models moving there – MACRA may actually do that.”

“The healthcare industry is large, conservative and is slow to change. For decades, the fee-for-service payment model has been in place. The entire industry is still operating along a volume based model for revenues. In some areas of the country, there are value based payments but even those models comprise a relatively small fraction of total revenues. Simply put, there is not enough incentive, or financial penalty, for providers to fully engage in the value based payment models.”

A non-clinical health care leader perspective from one who also responded to the survey is,
“…that most ambulatory groups are unsure of what exactly to do to impact the changes required. Because it has not become a significant percent of reimbursement, they are not yet forced to change. But, these same groups will be surprised and unprepared when the time comes.”

“Value-based revenue is available now to facilitate the necessary transition from volume to value” (Burris 34-37). There are programs that are already programs such as Medicare Wellness and Chronic Care Management that are reimbursable, address wellness and the implementation of which will help to facilitate the transition from volume to value. Why wait?

It is clear that there will be a tipping point when the financial pain of increasing penalties for suboptimal care will force hard choices by providers. The successful value based providers will continue to thrive. It is also clear that the health care industry will continue to see massive consolidation with larger, more successful value based providers becoming the standard over the next several years. Providers who cling to a volume based strategy will be hard pressed to survive in the new environment.

For now, CMS is defining quality based upon the current quality reporting programs of PQRS, MU and VBPM. These programs will be combined into one overall quality program for the MIPS reimbursement model. There is some flexibility for the providers to choose quality measures that are most applicable to their practices. There are four components to the MIPS scoring that include clinical quality, resource utilization, clinical practice improvement activities and advancing care information. MIPS is budget neutral so there are both financial rewards and penalties in this program, which start at 4% in 2019 and increase to a maximum of 9% in 2022. For the first year, quality reporting under APM is consistent with MIPS quality reporting (MACRA slide deck).
There is no escape from the pressure of payment reform that is already upon us. It will impact how we provide patient care and coordinate care across the health care continuum and ultimately redefine financial success from productivity and volume to quality of care, improved outcomes and cost efficiency. The rapid payment shift toward value and away from service volume will impact each provider and how care is delivered. The quest to maximize volume of services will be supplanted by a strategy to efficiently manage the overall health of a large number of people, i.e. population health, in the communities we serve. For health systems the current drivers of revenue are volume of services, specialty and intensive care, surgical procedures and inpatient stays. In the new reimbursement environment, which supports population health management, the drivers will transition from an inpatient focus toward primary care outpatient or ambulatory providers.

Population Health Management – The Ultimate Goal

Population health can be defined as a ‘cohesive, integrated, and comprehensive approach to health care that considers the distribution of care, and the policies and interventions that impact and are impacted by the determinants” (Nash 14). This is a very broad definition, likely broader than most of us in health care currently consider. The typical reference to population health discussion is simply the physical and mental health component without consideration for other drivers of health. True population health includes the obvious physical and mental health with which we are all familiar. However, since more than 50% of health determinants are related to lifestyle, it is clear that a discussion about the full scope of population health includes determinants such as socioeconomic status, geographic region in which people live, race, ethnicity (Nash 15). The list goes on. But, the goal of this paper is specific to the direct relationship of health care to patients’ overall health. The important note to take from the broader topic of population health as defined here is that solving the issues of the patients’ health is just
the beginning of understanding and addressing the health of a population. But, it is a good first step to achieving the overarching goal of population health in the broader sense.

In addition to the legislation that has been enacted at the Federal level to drive improved health, the federal government has also been involved in initiatives that promote population health. Two examples of these programs are The National Priorities Partnership and the Health People Initiatives. First convened in 2008, The National Priorities Partnership of 28 public and private organizations agreed to a goal of addressing four major areas of concern in our health care systems. The four areas focus on the disparities of care among social classes, reducing their disease burden, which can be greater with certain socioeconomic classes, eliminating harm to patients and reducing waste. The “Healthy People Initiatives” is the second significant effort on the part of the federal government to improve the health of the population. The focus in this program is to develop initiatives that promote improved quality health care that increase the years of life and, as with the National Priorities Partnership, focus on removing the disparities of care among social classes (Nash 15). It is common knowledge that health care spending is just below 20% of Gross Domestic Product (GDP) and projected growth is approximately 5% annually so it is not surprising that the federal government has been focused on reducing costs. Payments to providers must be aligned with this drive to value in order to effect change. Primary care practices that partner with their community to improve health, maintain wellness and effectively manage people who have chronic diseases will be successful in the new model of value based reimbursement. This effort will require an engaged care team at every step in order to be successful.

The diagram below represents the Population Health Pyramid of Care. This was developed and shared by David W. Bowers, MD, a family physician with 35 years of experience.
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Figure 1 - Pyramid of Care & Costs

The pyramid represents the various levels of care provided depending upon a patient’s level of wellness and associated medical conditions. As is depicted in the pyramid, there is a direct correlation between the level of care and the cost of care. The further up the pyramid a patient’s needs are, the greater the cost of care. One of the largest health care expenditures is related to the care of people with chronic conditions. The new imperative for optimizing health is to encourage wellness, screen for and manage risk factors and, ultimately, to help everyone be as healthy as possible. The ultimate goal is for patients to remain healthy, for providers to properly identify and manage risk factors, efficiently manage chronic conditions, avoid complications, and keep the patient as close to the bottom of the pyramid as possible. If successful, the result is improved health as well as cost savings. Some have said that there is little reduction of cost associated with wellness. While this may be accurate, it is the cost avoidance over time that generates the real
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Savings (Nash 148). This savings applies to patients that are able to maintain their health through wellness efforts as well as patients with chronic conditions who are able to control their disease(s), slow the progression and extend the period of time they are asymptomatic thereby avoiding costly procedures and hospitalizations. Successful provider groups will embrace the concept of wellness and effective disease management to create a culture of health for their patients. Successful health systems will partner with their community to keep them well through broader efforts that include the less obvious drivers of health, e.g. socioeconomic status, ethnicity, etc.

Case Study – A Path to Team Based Care

This is likely the greatest opportunity for improving community health since the establishment of Medicare in 1965. It is all about change management. How do we change our care delivery models to address these changes and new expectations? Certainly, we cannot execute a ‘big bang’ change as we would if we were migrating to a new revenue cycle platform. Patient care innovation requires a more complex and subtle approach. The change management process suggests a stepwise process to change how we deliver care. A good strategy for initial success is choosing a program that impacts a significant number of people in the practice and improves quality of outcomes and reduces the cost of care. The following case study is an example of a small step into successful value based payment, which led to a broader implementation of team based care. In this example it is evident that success at the ambulatory level can have a profound impact on an entire health system.

In this case study, a health system employed ambulatory medical group, largely comprised of primary care had a department of four administrative nurses responsible for all clinical quality initiatives and an operations team responsible for managing how care was delivered. The administrative nurses were continually rolling out new quality initiatives designed to improve
patient outcomes consistent with the quality reporting initiatives. The operations team was charged with improving productivity and patient access to care. The efforts of these two teams were occurring independently with no collaboration. The practice site care teams were caught in the middle of trying to continue to provide care as the operations leadership expected as well as managing each new initiative as the administrative nurses expected. While the operations team was experiencing some success at improving productivity and patient access, the administrative nurses could not get traction with their initiatives. Both teams failed. Everyone was frustrated! Each team was complaining about the other’s efforts and the negative impact it was having on their own attempts at improvement specific to their area of responsibility. It was at this point that the senior leadership brought both the operational leadership team and the administrative nurses together to begin to collaborate and make each initiative a joint effort working towards improved quality and outcomes as well as improved productivity and patient access. The teams began to work as one.

Shortly after the new quality and operations team was formed the health system entered into a shared risk agreement where they were at risk for $2 million of quality incentive pay from a commercial payer. In order to achieve the incentive, the health system’s employed ambulatory group was required to close 1,000 care gaps over a few months. Failure on the part of the ambulatory practices would mean that the health system would forfeit incentives for which they would otherwise qualify. The ambulatory practices would also fail to achieve their own quality incentives. The project objective was to improve quality outcomes for the employed practices, close care gaps and, ultimately, qualify all entities for the quality incentive payments. The health system owned medical group quickly made this the focus of the administrative and clinical leadership team that had recently been formed. The new goal of this collaboration was to develop and implement a Team Based Care delivery model, comprised of both clinical and non-clinical
members of each practice. A clinical team member of each site was appointed as a care
management coordinator. The role of this coordinator was to review the list of patients with gaps
in care that was provided by the commercial payer, identify the gaps then serve as the liaison
between the practice site and the patients to coordinate the care necessary to close the care gap(s).
For example, the care management coordinator would identify patients that were women over 40
who had not had a screening mammogram, contact the patient to coordinate the appointment for
the mammogram and follow up with the patient to ensure the test was performed. Another
example of closing gaps in care would be anyone fifty years old or older who had not yet had a
colonoscopy. Again, the care management coordinator would contact the patient to coordinate
scheduling the colonoscopy then follow up to ensure patient compliance. The result was that
greater than 1,000 care gaps were closed in only four months, which meant that both the health
system and the medical group each qualified for the incentive payments. Led by the combined
administrative and clinical leadership and implemented by the practice sites, in large part due to
the innovative changes created by the management team, patient access and clinical outcomes
improved. Perhaps the most pleasant surprise was the medical group’s employee satisfaction
survey demonstrated significantly improved scores during this period of rapid operational change
essentially relaying to group leadership that the site care teams were engaged in the process
change that had occurred at each site.

The success with this project jumpstarted the path of team based, patient centered care delivery
reform. The next step was to identify and achieve additional value based incentive programs.
After a quality and financial analysis of potential projects, the medical group chose the Medicare
Wellness program. The family and internal medicine practice leadership agreed with this
initiative as the next step. The implementation approach was similar to the care gap project. At
the start of this initiative the primary care sites had experienced a volume of Medicare Wellness

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visits of 2% of the total eligible patients. There were two major hurdles identified by the leadership team, which was the same team that had experienced such success with closing gaps in care. These hurdles were the eligible patients did not understand what these visits were supposed to be and the physicians did not understand their role in the visits or how to maximize practice resources to most efficiently perform these Medicare Wellness visits. So, education began both simultaneously for the patients and the providers.

To educate the patients, marketing material was developed that explained the difference between an annual physical and a Medicare Wellness visit, which most importantly is there is no physical exam as part of the Medicare Wellness visit like there is for an annual physical. It was further explained the Medicare Wellness visit is a health assessment that included discussion about things there is not typically time to discuss during a physical like depression screening, fall risk and advance care directives. This information was mailed to the patients with a letter informing them of their eligibility for the Medicare Wellness visit. All staff were also provided the literature and educated on each of these visit types so when they encountered a patient that had questions, they could respond appropriately.

The effort to educate the physicians, who were compensated based on work Relative Value Units (wRVU) was critical to the success of increasing the utilization of this visit type. It was helpful that Medicare had summarized how the Wellness visits were to be performed and at what level of licensure certain tasks around the visit could be performed. This understanding addresses the concern of the physicians of not having enough time to spend forty-five minutes with a patient. When the physicians understood that a Certified Medical Assistant (MA) could, according to CMS, could perform two-thirds of the visit, they were relieved and willing to try. Of course, it helped that the wRVUs associated with these visits were greater than the highest level office visit.
Armed with these two pieces of information, the physicians were willing to try the Medicare Wellness visits.

Within six months of starting the initiative, patients’ utilization of Medicare Wellness increased to 38%. Physician compensation was, in part, related to w-RVU production. CMS assigned high value w-RVU’s to Medicare Wellness services, which became a tailwind for physician buy-in for this initiative. Primary care provider buy-in is essential for any ambulatory or health system incentive program. CMS clearly understands this perspective. Just as the health system and medical group are compelled to change to manage the financial viability of the practice, the providers are also motivated in part by aligned incentives. This is a factor that must be considered as part of a change management strategy. Clearly, all financial incentives must be aligned.

Both of these programs, closing care gaps and Medicare Wellness, served to create a collaborative team among administrative leadership and clinical leadership. That synergy was a catalyst in creating sustainable change at the practice sites. The unintended but positive outcome was the level of employee satisfaction and engagement that resulted from the development of team based care and asking the licenses staff to work to the top of their licensure. This medical group continued down the path of change management and success in value based reimbursement. As a result, the group solved a significant patient access issue and experienced a material positive impact on the overall financial performance of the group as well as the health system.

Case Study – A Collaborative Shared Risk Agreement

In this case study, a large self-insured employer faced rising health care costs. The majority of health care services were provided to the employer’s health care beneficiaries by two local health systems. Both health systems had similar quality performance. However, one health system had
consistently higher utilization and costs over a several year period. The higher cost health system risked losing preferred provider status with the employer if they did not reduce costs while at least maintaining the same level of quality. The higher cost health system and the employer entered into a multi-year risk sharing agreement under which the health system received an ‘average’ HMO base capitation. In addition to the capitation payments, there were also value based incentives / penalties related to achieving high quality and low cost outcomes based on quality of care / service and cost measures that were established in advance and monitored quarterly.

The agreement affected only the HMO population of the health plan therefore, there was a built in control group of the non-HMO beneficiaries. The employer rewrote their health plan for the HMO population to require the selection of a primary care physician (PCP) of the health system medical group. Managing the HMO population fell to the health system owned medical group. So, the PCP office operations were reorganized to support the team based care approach and expand it to include health system staff as well. Care coordinators previously designated at each office were given patient lists then, as they did with the efforts to close care gaps in the previous case study, they did outreach to the patients encouraging them to take advantage of preventive services as well as provided guidance and serve as a resource for managing their health whether it was wellness or chronic disease management. The significance of this case study is that the office-based care coordinators also worked closely with the health system discharge planners and the care navigators. There was a concerted effort to plan care from the moment the patient presented for care at the hospital, whether at the emergency department or as an inpatient, through the time of discharge and follow-up. The care navigators were essential in provided very specific support to the patients addressing any health care need they had. It could be as small as helping patients understand how to eat health at fast food restaurants. One care navigator shared
a story of a patient and their family struggling collectively with obesity. The family had such a busy life style that the majority of their meals were purchased at fast food establishments and they just could not find an alternative. So, the care navigator sat with the parents and educated them on how to eat healthier even at McDonalds. The parents appreciated that the care navigator was not pressuring them to prepare all their meals at home but recognized their life style and worked within that to help them begin their journey to wellness by eating healthier.

The results were impressive as the employer experienced a 0.5% year-over-year increase in health care expenses for the control group. All other employer health plan beneficiaries saw year-over-year increase of 8.8%. The health system saved $2 million and preserved market share. For the employer, the total savings was $300,000, which if extrapolated to all of their health care beneficiaries would be an annual savings for the employer of $6 million. This savings was achieved through decreased emergency room visits and hospitalization rates as well as length of stay. The quality of care measures actually improved. This program received local and national recognition through the Business Coalition on Health. Additionally, the health system was one of a handful of hospitals in their state to achieve a 5 out of 5 rating for avoidable hospital readmissions.

Both of these case studies demonstrate the value of implementing change in the care delivery model. Ultimately, ambulatory practice leadership must identify the best strategy to implement that is specific to their care delivery model in order to achieve value based reimbursement successes, as demonstrated in the above case studies. Clearly, a collaborative and innovative team with vision, determination and fortitude can achieve successful changes as payer incentives become more aligned with both quality of care, improved outcomes and reduced costs.

Review of survey and interviews
In an effort to understand the thinking of health care leaders, a survey of nine multiple choice questions was conducted then followed by interviews for clarification. There was an 85% participation rate. For reference, the questions are below:

1. Except for the most progressive health care systems and providers, the health care industry as a whole seems to be struggling with the transition from volume to value and under estimates the time and effort necessary to execute the strategic, operational and financial change management. Why is that?

2. What will health care systems and groups need to make the transition to change?

3. Have you made or started the transition from volume to value?

4. Where are you in the transition to value?

5. Have you modified your physician compensation model to support your transition to value?

6. How has patient care changed as you transition to value?

7. How have you engaged operational and clinical leadership in this effort?

8. Have the essential components of your care team changed?

9. Are you successful in your efforts to transition from volume to value as defined by CMS by improvement in the following: quality scores, patient satisfaction scores, i.e. Consumer Assessment of Healthcare Providers & Systems (CAHPS), reimbursement and reduced costs?

There is consensus among those surveyed that reimbursement for volume is still too lucrative so there is no real incentive to change and that change will need to be forced through greater downward compression on reimbursement including additional penalties. Given the timeline put forth by CMS to increase the quality and cost effectiveness components of the reimbursement, this downward compression will be upon us before we know it. As quoted earlier in this paper, ‘…MACRA may actually do that.”
The respondents did also indicate that they had begun the transition to value and were engaging in at least one, if not multiple approaches to address the need to change how care is delivered.

There is also consensus that practices are becoming Certified Patient Centered Medical Homes and simultaneously increasing reliance on the team concept of care as they transition from volume to value. For those that want to be considered for the APM reimbursement track, the certification is a key component and the transition to team based care will drive success in that reimbursement model. At a minimum the respondents were making the transition from the physician being at the center of the care team to putting the patient at the center with multiple touch points within the care team beyond the physician. This is consistent with data from MGMA survey data that indicates those respondents are also taking steps into clinical integration including care coordination between offices and across the health systems. Some are advanced enough to also be including health plans and payers too (Grimshaw 24-34)

A significant point from the survey is that, for the most part, executive leadership is engaging operational and clinical leadership in decision making by including the point of care leadership to as part of the planning and decision making team for the changes being made to patient care. This is an essential component to success as the engagement level is much higher when those doing the work have a voice in how the care delivery is being changed. In the first case study included in this paper, the employee satisfaction scores went up after the implementation of a team based care model in large part because they were engaged and working at the top of their license, which supports this survey finding.

One note of concern for lasting success is found in response to the question regarding alignment of physician compensation to the value proposition. There was a resounding ‘no’ answer to the question of whether or not physician compensation had been modified to support the transition to value. However, an article in the MGMA Connection magazine states that their members are
beginning to transition to compensation models that reward quality outcomes (Grimshaw 24-34) historically, to achieve success in health care initiatives at the practice level; the compensation model has been aligned with the goal you are trying to achieve. It is a well known adage that you get the behavior you incent and that will be critical in the transition to value as the physicians need to be engaged and supportive to drive long term success.

One respondent noted another area of concern. Their practices are making the transition from volume to value but it is such a small percentage of the total that they are unsure if what they have done will be scalable to have the same impact on the larger population. This is a reasonable concern.

Summary

Health care has been an issue for our federal government since not long after the United States was founded in 1776. The first legislation occurred in 1798 and addressed the issue of access to care. That means that our federal government has been trying to address health care issues in this country for over two hundred years! The two major historical issues have been, and still are, access to quality health care coverage and managing the associated cost of that care. It is difficult to believe but we are still talking about solutions to the same problems of so many years ago. There have been numerous efforts to legislate changes that support both of these initiatives. However, with the exception of the creation of Medicare, which was the single most effective legislation in creating coverage for a large sector of the population, the other legislative efforts have been only marginally successful.

It is the Patient Protection and Affordable Care Act of 2010 that has thus far proven to be the most impactful in the efforts to ensure heath care coverage for as many people as possible in the United States. Directly following the ACA in 2015 is MACRA, which addresses the issue of cost but also includes the important quality of care component. These two major pieces of legislation...
are a culmination of the frustration of the federal government with the health care industry and our inability to fix a problem we helped create. Since the inception of Medicare, health care providers have been reimbursed on volume alone. In fact, we in health care played a significant role in creating the current crisis in the industry. There was a point in time several years after the inception of Medicare that providers learned that Medicare would pay whatever charge amount that was billed. This created a situation where providers were inflating charges to maximize reimbursement with little regard for the impact, and why not? Medicare did not question the charges, so it must be ok. Providers were driven by volume in the fee-for-service environment. Managed care was an effort to address the increasing costs but that initiative became more about denying access to care than providing appropriate, quality care. Therefore, it was ineffective.

As an industry, we have left the government no choice. We have not recognized our part in the escalating costs and lack of attention to quality. The ACA and MACRA are the best effort of our government to inform the health care industry that they have reached the pinnacle of frustration at our inability to fix our own issues. The federal government is driving the change that the health care industry has been unable to effect on their own. They have decided that they will pay health care providers for value and have seized control of the health care industry through payment reform.

If you consider the history of the government’s efforts to effect change, the pace of that change is not as quick as we have perceived. Health care is seeing a new day in America. When you consider how patient the government has been, waiting 200+ years, in allowing the industry to correct itself, it seems reasonable that the ACA and MACRA legislations became law and the pace of change is at an exponential rate.

Where we are today in health care is that the government will now pay for value and managing the health of whole populations versus a few thousand patients per provider. The technological
advancements have provided the data for the back drop of this transition to value. Quality data can be measured, reported then acted upon to effect improvement.

As demonstrated in the Pyramid of Care, the further down the pyramid a patient remains, the greater the cost savings or the cost avoidance of future health care spend, to put it another way. Also noted on the Pyramid of Care, is that the primary care team is integral at the first two levels, which include wellness, preventive services, health risk assessments, clinical screenings, etc. As evidenced in the case studies, groups that embrace change and see the value of a care team versus the physician as the only provider of care will be successful in the new reimbursement environment where value is rewarded as opposed to just volume. It is essential to begin making changes now to support the current volume and value reimbursement environment, which will prepare you for the evolving reimbursement environment to value and outcomes.

Primary care plays an essential role, and in fact holds the key to success, in the new paradigm of health care. The paradigm shift is moving away from the hospital centric, procedure focus of just yesterday. The time to change is now. Successful medical groups will manage through the reimbursement changes by embracing new models of care delivery and a recognition of the primary care team as the driver of care. Couple that with comprehensive data that will help drive quality as well and primary care that will successfully lead the population health initiatives and will eventually be the drivers of health care.
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