

The Era of Value:  
Navigating the Transition from Volume to Value

Exploratory Paper

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**ABSTRACT**

The healthcare industry has historically rewarded providers based on the volume of services rendered, rather than the value of those services. Through the commitment and direction of the Department of Health and Human Services, new programs and legislation have been created to tie provider payment based on the achievement of the Triple Aim: improving the patient experience, reducing cost, and improving the overall health of the population. As a result, new programs and legislation have emerged. This has resulted in the need for cultural shifts, new skills, and new technology for health systems, providers, and patients. This exploratory paper will provide insight through an in-depth literature review, focusing on changing practice culture, creating and modifying relationships with stakeholders, investing in new technology, and engaging patients and their families.

**KEYWORDS:** care transformation, value, accountable care organizations, bundled payments, volume to value, alternative payment methods, operations, care coordination

### INTRODUCTION

On January 26, 2015, the U.S. Department of Health and Human Services (HHS) released a historic statement outlining the timeline and overarching future strategy for the Medicare program. The release, titled “*Better, Smarter, Healthier,*” announced the goal of HHS to shift the Medicare reimbursement program from volume to value, paying providers based on quality and outcomes rather than the quantity of services provided. Specifically, by 2016, the goal is for 30 percent of Medicare payments to be tied to “alternative payment models” rather than traditional fee-for-service reimbursement. This goal is set to rise to 50 percent of all Medicare payments by 2018. These alternative payment models include: Accountable Care Organizations (ACOs), patient-centered medical homes, and bundled payments based on episodes of care. In addition, HSS set a goal that 85% of all Medicare payments will be tied to broader quality programs by 2016; increasing to 90% by 2018.

This statement was deemed pivotal and historic by the Department, as it sets the tone for the direction of the Medicare program, not only for the next few years, but for the overall future of healthcare reimbursement. Since these goals were set forth, there has been further action taken to solidify the payment methodology transition. On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Medicare Access and CHIP Reauthorization Act (MACRA). The main objective of MACRA is to streamline the current quality reporting systems within CMS, while also expanding the role of alternative payment models as a means of rewarding providers for giving better care rather than more care.

In addition to the government programs further developing and calling for healthcare payment reform, the private sector has also followed suit in many regions. In December of 2014, United Healthcare and the University of Texas MD Anderson Cancer Center developed a Centers of Excellence program that incorporates a bundled rate for specific types of head and neck cancers. The motivation surrounding the deal was to reduce the variation of care in oncology, thus increasing quality and driving down cost (Herman, 2014). Similar arrangements can be

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found across the country involving additional private payers as well as self-insured employers. Centers of Excellence arrangements, such as these, shift payment and outcome risk more on to the healthcare providers and will require new skills and resources to be successful.

While many institutions have “dipped their toes” in value-based reimbursement models through various pilot program or private payer initiatives, as these payment models continue to become more refined and required of healthcare providers, it is more important today than ever before to understand what is involved and required in order to succeed in this new environment. Value-based care boasts the expectation that costs will be driven down and patient outcomes will improve, however the operations and costs required to achieve this are practical considerations that must be addressed.

The purpose of this paper is to provide additional information regarding the transition from volume to value in the healthcare industry through an extensive literature review assessing the current and historical payment structures along with piloted and proposed Alternative Payment Models (APMs). Finally, a framework of key APM implementation strategies will be collected for medical practice managers to achieve success, with consideration given to: changing practice culture, creating and modifying relationships with stakeholders, investing in new technology, and engaging patients and their families.

### **THE CALL FOR VALUE: FEE-FOR-SERVICE REIMBURSEMENT**

In order to best prepare for changes in payment methodology, it is important to understand today’s most predominant payment structure: fee-for-service. With a fee-for-service payment model, healthcare providers are paid based on the quantity of work performed. For example, a physician and/or hospital would be paid a pre-determined amount for a specific procedure or patient visit, categorized by Current Procedural Terminology (CPT) or Diagnosis-Related Groups (DRG) codes. No matter the patient’s outcome or satisfaction, payment is issued at the pre-determined amount. In March of 2013, the National Commission on Physician Payment Reform was created and acknowledged that the level of spending within the United States was

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not sustainable. While several factors contribute to this, fee-for-service payment methodology creates an environment where the incentive is for healthcare providers to issue more care, no matter the cost to the system. This actively encourages duplicative or unnecessary treatment and hinders care coordination efforts (Shroeder & Frist, 2013).

According to the Virginia State Health Care Cost Containment Commission (2011), the average annual healthcare cost per individual in the United States reached \$8,860, more than twice the average than any other developed country in the Organization for Economic Cooperation and Development (OECD). If the current delivery methods remained constant, this number is on pace to reach \$14,103 per person by 2021. Virginia's Commission deemed that the fee-for-service structure was a major root cause for the current healthcare environment and the goal was set to replace fee-for-service with payment structures that incentivized coordinated, high quality care and held organizations accountable for controlling costs.

While the method in which healthcare providers are paid has played an integral role in how healthcare is delivered in this country, there are other factors involved contributing to the high cost of healthcare and lack of quality. In the current system, consumers are poorly informed of cost when making health care decisions. Aside from payments made to insurance companies through co-payments, co-insurance, and deductibles, patients rarely directly pay for the cost of their care. Historically, healthcare is consumed on-demand where patients have even less information, or time, to consider cost of care before services are rendered. If the care is elective, or non-emergent, choice of provider and/or treatment is typically based on convenience, family or friend referral, or technology of the treatment, where a higher price tag may be deemed as a directly correlation to the quality care (Yakovenko, Zuehlke, Daugherty, Pratt, & Drakes, 2015).

As the healthcare industry moves towards this "era of value" through new payment delivery models, it will be vital for medical practice managers to engage with providers, payors, and most importantly, patients in new ways in order to better control costs.

## **EVOLUTION OF VALUE-BASED PROGRAMS AND PAYMENT MODELS**

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While the announcement made by Health and Human Services was unique in that it provided unprecedented detail surrounding the Centers for Medicare and Medicaid's (CMS) shift towards value, Medicare payment innovation has been active for several years primarily through demonstration projects, organized through the Centers for Medicare and Medicaid Innovation Center (CMMI) as set forth by Congress through the Affordable Care Act. CMMI has organized these initiatives into six categories. Figure 1 lists these categories along with several program examples (Centers for Medicare & Medicaid Services, 2015).

**Figure 1. CMMI Value-Based Payment Initiatives**

Accountable Care	<ul style="list-style-type: none"><li>• Accountable Care Organizations</li><li>• Medicare Health Care Quality Demonstration</li><li>• Nursing Home Value-Based Purchasing Demonstration</li></ul>
Episode-Based Payment Initiatives	<ul style="list-style-type: none"><li>• Bundled Payments for Care Improvement (Models 1-4)</li><li>• Comprehensive Care for Joint Replacement Model</li><li>• Oncology Care Model</li></ul>
Primary Care Transformation	<ul style="list-style-type: none"><li>• Comprehensive Primary Care Initiative</li><li>• Independence at Home Demonstration</li></ul>
Initiatives focused on the Medicaid and CHIP Population	<ul style="list-style-type: none"><li>• Strong Star for Mothers and Newborns Initiative</li><li>• Prevention of Chronic Diseases Model</li></ul>
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	<ul style="list-style-type: none"><li>• Health Care Innovation Awards</li><li>• State Innovation Models Initiative</li></ul>
Initiatives to Speed the Adoption of Best Practices	<ul style="list-style-type: none"><li>• Community-based Care Transitions Program</li><li>• Health Care Payment Learning and Action Network</li></ul>

The majority of the initiatives created under these umbrellas have been voluntary and predominantly categorized as pilot programs. As healthcare providers, it is important to maintain a watchful eye over these pilot programs as examples for future mandates that will help HHS fulfill its goal of increased payment reform within the next several years. Programs such as the Hospital Readmission Reduction Program and Value-Based Purchasing began as voluntary initiatives, but have evolved into required measures with both positive and negative financial incentives.

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With the onset of MACRA, two payment pathways for physicians have been proposed. This will include the creation of the Merit-Based Incentive Payment System (MIPS). MIPS will combine programs such as the Physician Quality Reporting System (PQRS), the Value Modifier (VM) and the Meaningful Use Incentive Program into one singular reporting program. The second pathway is participation in Advanced Payment Models (APMs). MIPS provides the option of maintaining a fee-for-service reimbursement system, with greater reporting emphasis placed on quality metrics, whereas physicians who qualify and participate in an APMs will be exempt from MIPS for their ability to adopt new payment models. Both MIPS and APMs will involve both upside and downside financial risk opportunities for physicians. At the time of this submission, a final rule on MACRA has not been released. While modifications may be made prior to 2017, medical practice managers must prepare for participation in one of these two tracks. According to the American Medical Association (2016), the majority of providers and provider groups will participate in MIPS due to the limitations on eligible APM participation. Aside from CMS, medical practice managers can still participate in value-based payment models outside of the context of MACRA and at a minimum lay the groundwork for future mandatory participation.

The most popular of the value-based payment initiatives have been participation in Accountable Care Organizations (ACOs) and bundled payments for episodes of care. Since the passing of the Affordable Care Act there have been several iterations of ACOs. Generally, they consist of integrated groups of doctors, hospitals, health systems and other healthcare professionals who work to provide coordinated care for a group of patients, often determined by insurance provider, medical condition, or both typically on an annual basis. Bundled payment initiatives involve many of the same care coordination efforts as an ACO, but the focus is around a singular episode of care and typically involves a time period of 60-90 days. CMS facilitates both ACOs and bundled payment programs, but this is also expanding further into the private payor, direct-to-employer, and direct-to-consumer markets (Lazerow, 2014).

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With both ACOs and episode of care bundled payments, the push towards value is achieved through extending financial risk onto the healthcare delivery system. Healthcare providers who engage in these programs have the opportunity to receive the historical cost data from the participating payer. From this data, a target episode-spend is established. If the provider can reduce this spend, they have the ability to share in the savings, so long as certain quality metrics are met. These quality metrics often include readmissions, infection rates, and overall patient satisfaction.

As these programs have matured, providers are also becoming responsible for downside risk, paying back any excess of the historical target. This has become the predominant "game-changer" for healthcare systems, as failure to succeed under these programs now has significant financial implications. The pilot versions of these value-based payment models have shown success, especially for reducing the overall cost to CMS. On April 1, 2016, CMS began a mandatory bundle payment initiative, Comprehensive Care for Joint Replacement (CJR). The details of this program are similar to the voluntary Bundled Payment for Care Improvement (BPCI) pilot program, however 67 metropolitan service areas were required to participate. Programs similar to CJR for medical episodes of care and other specialties have also been proposed. Given this, it is crucial for providers to prepare for expansion of value-based payment programs.

### **KEYS TO SUCCESSFUL IMPLEMENTATION OF VALUE-BASED PROGRAMS**

Today, participating in a value-based payment model or APM either begins with the voluntary entry into a contract between provider and payer, or, with more recent examples, by default based on types of procedures performed or the service area the provider performs the case in. Regardless, once the agreement is made, there is significant work that must occur in order to achieve both financial and clinical success.

Operational effectiveness requires analysis of current operations and an understanding of what additional resources are required. The main factors involved include: creating a value-based

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culture, alignment of stakeholders, investment in new technology and resources, and increasing the role of the patient and their family in the plan of care.

### *Creating a Value-Based Culture*

As previously cited, the fee-for-service methodology tends to deter care coordination. Providers are consistently compensated for their portion of work, regardless of previous intervention, outcomes experienced by the patient, or the amount of services required by other healthcare providers. With value-based payment models, the incentives have changed. Providers and health systems now have increased interest in long-term patient outcomes, rather than just the time the patient is in the physician office or inpatient floor. Putting this mindset into action requires changing years of practice habits. Driving cultural change may prove to be the most challenging aspect of implementation (Haas, Kaplan, Reid, Warsh, & West, 2015). In the fee-for-service environment, ordering tests, performing procedures, or discharging patients from the hospital with costly post-acute services was what kept the lights on and often made patients feel satisfied with the level of care they were receiving. In a value-driven world, pathways of care need to be established in order to conserve resources and produce optimal clinical outcomes for patients.

The Association of American Medical Colleges is starting to incorporate value-based care theory as a standard element in physician education. Curriculum is being modified to incorporate the realities of the cost of medicine and how if high quality medicine is used from the beginning, the overall cost will go down (Glicksman, 2015). While this is promising for the future, large-scale cultural change needs to occur on all levels of organizations providing healthcare in these alternative models.

It is important to identify champions of these changes on all levels: physicians, nursing, therapy and administration. APMs require enhanced care management to reduce gaps in care and increase overall engagement so as not to incur unnecessary expense or adverse outcomes for patients as they progress. Once the healthcare system or medical practice is engaged in the

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rationale behind this change, it will be important to continually question current state to ensure that for every patient, every test, treatment and plan of care is done with diligence to uphold quality of care and with sensitivity for the costs incurred by the system.

### *Aligning Stakeholders through New Relationships*

Cultural shifts will be necessary at all levels of the care continuum in order to truly shift the mindset from volume to value, however connecting people and organizations involved in this continuum will require new relationships to be developed and increased engagement for existing partnerships. Risk-based value-based payment models look at the larger patient experience within the health system. A highly common bundled payment procedure is a total joint replacement. In the BPCI program, Medicare looks at the 90 day episode of care and reconciles payment based on historical costs. While the inpatient stay is the most costly piece of the 90 day period, accounting for about fifty percent, in terms of days the index admission accounts for only three percent of the total episode. The next most costly area, accounting for over thirty percent, lies in the post-acute care setting. Included in this is skilled nursing, inpatient rehabilitation, home health and physical therapy (American Hospital Association, 2013).

Physician involvement is unique in that their payments only account for ten to eleven percent, but physicians have a large influence on patients' interactions during the episode of care. Physicians serve an important role in setting patient expectations and encouraging patients to seek care in the most appropriate setting. Historically, physicians provided patients with a list of post-acute care providers based on convenience and insurance benefits, referring to an average of 18 different providers with minimal vetting to ensure quality of care (Abrams & Philips, 2016). Recognizing that in most cases, either the physician group or hospital is at risk in these arrangements, it is vital that relationships with providers in the post-acute care setting are developed.

BPCI does allow for agreements involving "gainsharing", meaning that providers with influence on the cost of an episode can also share in the risk and potential savings. While this

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may be the best strategy to align physicians with the goals of the bundle, it may not be an appropriate incentive for all providers involved with patient care. The alternative is to incentivize post-acute care organizations through the creation of preferred networks. Post-acute care providers who agree to meet certain quality standards, such as reducing readmission rates and achieving appropriate lengths of stay, and execute standardized care pathways will be deemed as partners to physician groups or hospitals. Establishing this framework will allow providers to better assist patients in making informed choices on where to seek care post-discharge.

Increased communication and data sharing is also necessary when working with preferred post-acute care providers. Frequent updates regarding transfers in care, milestone achievement, or changes to protocol are necessary in order for the at-risk provider to monitor patients and keep costs in control.

### *Investing In New Technologies*

Success in value-based payment models will require investment on multiple levels from the participating provider or hospital. This can include new staff, billing methods, and care management technology. Specifically, the technology aspect of implementing value-based payment programs can be broken down into claims data analysis and patient care coordination.

Data analysis is the bloodline of risk-based payments. Historical data provides a guide for where to target cost-reduction efforts and to understand what characteristics patients may have that will lead to a higher-cost episode of care. Much of this can be done through leveraging data within the electronic medical record, through chart and claims review; however, obtaining complete payor claims data is critical to understanding the drivers of cost within an episode of care. Access to this data can be challenging, as CMS only provides this level of data for providers participating in pilot programs or APMs. However, starting with internal data and understanding referral patterns can provide insight and help to drive physician behavior towards cost reduction (Bahl, 2016).

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Once the episode type or patient population is defined, additional technology will be required to coordinate the care of the patient during the extended timeframe. Multiple care coordination tools have been created in conjunction with the development of the Medicare payment programs. The available tools will likely continue to rise considering in the first quarter of 2015, the healthcare market saw a record amount of funding of \$3.9 billion towards startup companies (Billings, 2015). New technology tools can provide an improved method of communication across the entire care team. Much of the healthcare system currently operates with some level of electronic medical record system, but it is rare when provider groups, hospitals and post-acute care organizations' systems can easily share data with one another. These newly developed products are often cloud-based and allow for fluidity in providing custom care plans for each patient. Internal tools to aid with tracking and reporting quality and cost metrics will be important to develop as submission of quality metrics are required within these contracts and internal costs must be controlled to help mitigate financial risk.

### *Activating Patients And Families*

Patients and their families or caretakers must be engaged with their healthcare in order to meet to demands of value-driven reimbursement models. At the core, these programs are designed to increase the overall health of patients and populations. Since much of the care episode duration occurs at the patient's home, or outside of the purview of the care provider, patients and families must have aligned goals with their healthcare providers.

With fee-for-service, patient demands often centered on what was covered by their insurance plans. This was met with little resistance since the increased cost to the overall system had minimal impact to the primary provider. In a value-based payment world, patient, payer, and physician goals need to be aligned. Each intervention must be met with speculation on the impact to the patient's outcome as well as to the overall healthcare system. In order to engage patients with this shift in thinking, it is important to educate and set expectations before, during, and after a hospital stay or surgery, to encourage that care is sought at the right place and right time in

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order to achieve optimal outcomes. Geisinger Health System created a “patient compact” outlining the details of the care plan, setting goals, and focusing on outcomes. This helped lead to a 5 percent decrease in hospital costs (Rand Corporation, 2010).

Patients are also experiencing increased responsibility for the cost of their care and many are demanding improved transparency and autonomy with regard to their treatment plan. Providers must be able to make decisions and set goals alongside patients in order to set proper expectations and improve overall satisfaction of patients (Davenport-Ennis, 2010).

The investment of new technology to engage with patients around their care plans has multiple benefits. These tools provide advanced education tailored to individual patient needs to help reduce complications, readmissions, and overall improve patient wellness. The data from these tools can also alert care team of high-risk patients or when patients are deviating of the intended care path. This allows for the ability for providers to check in with patients before the situations progresses or to avoid unnecessary trips to the Emergency Department. Ultimately the patient plays a crucial and central role in achieving success under value-based payment models. Through aligning goals, lower overall costs with improved quality can be attained.

### **CONCLUSION**

The transition from volume to value-based payment methodology for healthcare providers has been a topic of discussion since the passing of the Affordable Care Act in 2010. The operations required to not only implement these new systems, but to succeed requires a transformation from today's methods in providing care. The concept of improving the value of care delivered to patients touches all aspects of the system. This type of change cannot be accomplished by narrowly focusing on driving down supply costs or by engaging health-care providers through risk-based payments. Rather, change at this level needs to be systemic and ongoing. The "era of value" applies to all who interact with patients and patient care delivery. It is through aligned incentives, enhanced relationships, improved technology, and accountability that there will be true results in the form of sustained profitability and improved patient health.

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The voluntary transition to value is quickly being replaced by mandated governmental programs, pressure from the private insurance markets, and even patients. It is the responsibility of medical practice managers to guide their healthcare providers and employees. Through the creation of a value-based culture, alignment of stakeholders through new-found partnerships or role creation, investing in new technology, and developing ways for patients and their families to be engaged in quality care, this transition will result in a solid foundation for a healthy future.

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