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Moving Medical Payments from Volume to Value Or From Quantity of Services Performed to Quality of Care Produced

By James L. Holly, MD
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In 2014, 49,435,610 were covered by Medicare, eight million of the beneficiaries are under age 65 and are on disability programs. On July 30, 1965, seven days before my wife and I were married, President Lyndon Johnson signed into law *Title XVIII of the Social Security Act* which created Medicare. At that time, there was great controversy about Medicare. Many physicians opposed Medicare. In the first 25 years of Medicare, its cost was much higher than expected. The reason for that begins our discussion about how health insurance payments area changing.

Medicare payments to healthcare providers began as a "piecemeal" system. The provider did a lab test and was paid. The provider did a procedure and was paid. This is an usual application of this term, "piece meal," but it describes how each service, procedure or event provided in healthcare was paid for by Medicare apart from any consideration other than that the event had occurred. Healthcare providers, who had previously often treated patients without charge, quickly realized that the more services which were provided, the more revenue was generated.

Medicare, initially, did not measure the quality of services, the appropriateness of services or the outcome of services. If a physician performed a thousand cardiac catherizations and only 50 were abnormal, no limitations were placed on that physician. Gradually, however, the medical community began to realize that some tests or procedures were being performed frequently but with little benefit to the patient or to health,

One of the earliest attempts to decrease the cost of care and the "over use" of healthcare procedures, tests and services, was spurred by the enactment of the *Health Maintenance Organization Act of 1973*. Instituted only eight years after Medicare, managed care techniques were pioneered by health maintenance organizations, they are now used by a variety of private health benefit programs. Managed care is now nearly ubiquitous in the U.S, but has attracted controversy because it has had mixed results in its overall goal of controlling medical costs. Proponents and critics are also sharply divided on managed care's overall impact on the quality of U.S. health care delivery.

The results of managed care were mixed as to decreasing the cost of care and maintaining the quality of care. Insurance companied promoted "managed care," but healthcare providers often felt that control of health care delivery and particularly healthcare decisions had been assumed by those who were not trained in medical decision making.

By the early 1990's, Medicare health maintenance organizations had evolved into Medicare HMOs which went through a series of name changes and which are not named Medicare Advantage programs. The best of these programs provided a real collaboration between healthcare providers and health maintenance organizations. Healthcare providers began to understand and to accept "risk," which means that they contracted with HMOs to assume some or all of the risk of providing healthcare services for a predetermined, contracted cost. In these relationships providers began to measure the quality of services which were being provided as well as to be sensitive to the cost of those services. The idea was to provide excellent care at a reduced cost. The healthcare industry began to accept the premise that excellent and expensive ere not synonyms.

Healthcare providers began to be compensated for the measurable quality of the services they provided and not just for number, quantity or volume of those services. Organizations were formed to accredit healthcare groups who were committed to the process of moving from the volume of services to the value of services performed or expressed a different way, which were committed from moving from the quantity for number of services preformed to the quality of the outcomes produced by the services performed.

Medical practices or groups of providers submitted their organizations to review and examination by the National Committee for Quality Assurance, Accreditation Association for Ambulatory Health Care, URAC and/or The Joint Commission. Such groups began to measure "quality metrics," standards of performance where were associated with the performance of certain tasks, not procedures, and/or which demonstrated certain outcomes. Accreditation and quality metrics were the first steps in changing the goals and standards of healthcare delivery.

In April, 2015, SETMA partner and Chief Medical Officer, Dr. Syed Anwar attended a conference in Las Vegas on Reducing Hospital Readmissions. On April 27th, he sent a note with a quote from one of the presentations given by Dr. Wilde, Chief Medical Officer (CMS) of Centers for Medicare and Medicaid Services (CMS), in which Dr. Wilde said: "Fee for service is dead. If you have a business plan that is based on fee for service then you need a different plan or start doing something else."

The transformation of payment methods for healthcare is being referred to as "Revenue Cycle Management". In May, SETMA's CEO was asked to give an address in Austin, Texas to Chief Financial Officers of healthcare organizations. The links below are to articles which address Value-Based Payment Reform. The articles are drawn from my responses to two sets of questions sent to SETMA's CEO by the Chief Financial Editor of the *Health Leaders Media*. He wrote an article about the Austin Conference and is preparing a major, cover presentation for September, 2015 *Health Leaders Media*. The Editor send a response to SETMA's CEO's Austin presentation which can be read at: http://www.jameslhollymd.com/Letters/response-to-dr-hollys-presentation-to-health-leaders-media, After reviewing the answers to his questions and after a telephone interview, the Editor said: "It is as I suspected, Dr. Holly: You and SETMA are ahead of the value-based payment model curve. Is there any area of healthcare reform you have left unexplored? You are an impressive reformist figure, with unique depth of experience. Eager to talk next week, Chris."

(emphasis added)

The two list of questions the Editor sent and my answers can be reviewed at the following links:

- Value-based Payment models, Last Group of Questions:

  http://www.jameslhollymd.com/Letters/value-based-payment-models-questions-for-the-industry- health-leader-media

  1. Why is capitation with fixed monthly payments a viable value-based payment model?
  2. Does capitation give physician practices a transformational edge by allowing flexibility to redesign care crafted to the local market?
  3. How can you use PCMH to generate value-based payment opportunities and revenue gains?
  4. Does EMR-based tracking of quality metrics help support advancement and adoption of evidence-based medicine?
  5. Mindset shift: A value-based healthcare industry will be financially lean relative to the healthcare industry's longtime volume-based business model. How do you convince physicians to embrace value-based care and payment vs. volume-based care and payment?

- Value-Based Payment Models, Questions for the Industry, HealthLeaders Media, Answers by James L. Holly, MD, April 2015
  http://www.jameslhollymd.com/Letters/pdfs/value- based-payment-models-questions-for-the-industry.pdf

  Eight questions about value-based payment models:

  1. What are the key factors for physician practices to consider when weighing involvement in value-based payment models?
  2. Industry-wide, gauge the trend for physician-practice uptake of value-based payment models?
  3. How do you organize physician practices to embrace value-based payment models? At physician practices, are there particularly daunting hurdles to adoption of value-based payment models?
  4. At SETMA, how have your clinical models of care changed to match value-based payment models?
  5. At SETMA, have value-based payment models driven down service volume? If utilization rates have declined, what impact has that had on the practice? If there has been a negative impact, did you find ways to offset that impact?
  6. At SETMA, what are the prime ways you are using data in conjunction with value-based payment models?
  7. How does changing from "volume" to "value" payment models affect measurement of patient experience of care?

8. What are the essentials of value-based payment reform?

This transition to value-based payments is well underway. It is as change always is, challenging but it is essential if we are to improve healthcare while making it affordable for all.