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Volume to Value: Transition Timeline Set for Medicare Reimbursement Payments

Prior to the implementation of the *Patient Protection and Affordable Care Act* (ACA) in 2011, payments through the Medicare system were tied to the volume of patients seen, procedures performed, and tests run, even if these procedures did not advance the patient's care. In an effort to achieve a "*better healthcare system*," the *U.S. Department of Health and Human Services* (HHS) identified three interdependent areas that, through pioneering and cutting-edge reforms, have the potential to improve patient care across the U.S. These three areas include: using flexible incentives to motivate high value care from hospitals, physicians, and other providers; delivering care through effective coordination, teamwork, and integration; and, accelerating the availability and utilizing the power of information to improve patient and provider decision making.[1] Since the implementation of the ACA, several programs have been established to help further these goals such as:

(1) Electronic Health Records and Meaningful Use programs;

(2) The Patient Centered Outcomes Research Institute (PCORI);

(3) National programs to reduce readmissions through transitional care and educate hospitals on addressing high priority risks to patient safety; and,

(4) The development and testing of new and alternative payment models including *Accountable Care Organizations* (ACOs), the Bundled Payment for Care Improvement Initiative, and new models for specialty and chronic care.[2]

In furtherance of this desire to establish a "*better healthcare system*," on January 26, 2015, HHS announced an initiative to transfer a large share of Medicare payments from the current fee-for-service model, paying for value rather than volume by incentivizing better outcomes and lower costs by rewarding quality and efficient care.[3] This monumental announcement was the first time HHS set specific goals for alternative payment models and value based models in the 50 year history of the Medicare program.[4] HHS plans to use internal metrics to track the progress of these goals and utilize population health statistics, currently measured and reported through Healthy People 2020,[5] to track quality of care improvements in the U.S.[6]

To explain variations between provider payment models, HHS adopted a *Centers for Medicare and Medicaid Services* (CMS) framework[7] that categorizes healthcare reimbursement by the type of justification for the payment.[8] Specifically:

(1) Category 1 describes a fee-for-service payment with no link to quality or efficiency;

(2) Category 2 describes a fee-for-service payment with a link to quality or efficiency of health care delivery system;

(3) Category 3 describes an alternative payment model built on the fee-for-service architecture where payments are still triggered by delivery of services but there is an opportunity for shared savings when high quality, cost effective care is provided; and,

(4) Category 4 describes a population-based payment that is not linked to volume of services but instead is associated with the volume necessary to provide quality and efficient healthcare to a group of beneficiaries for a long period of time.[9]

While categories 2 through 4 have a quality component related to payment and are considered a form of value based purchasing, transitioning from Category 1 (e.g. the current reimbursement model) to Category 4 (e.g. the ideal goal for reimbursement models) would require a greater focus on population health management,[10] a transition from responding to the acute needs of an individual patient to anticipating and shaping patterns of care across subgroups.[11] Population health management should:

(1) Improve the overall patient experience;

(2) Improve access to care;

(3) Promote patient engagement and allow patients to take responsibility in the management of their individual health;

(4) Lower the cost of care through an integrated delivery approach; and,

(5) Reduce the frequency of individual health crises.[12]

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Under this recently released plan, HHS anticipates 30% of its Medicare reimbursement payments will be classified under an alternative payment model (e.g. categories 3 and 4 of payment framework) by the end of 2016 and 50% by the end of 2018.[13] While this percentage may seem high, by the end of 2014, HHS already had 20% of its Medicare reimbursement payments classified under an alternative payment model. Additionally, HHS anticipates 85% of its Medicare reimbursement payments to have a quality or value component (e.g. falling in categories 2 through 4) by 2016 and 90% by 2018.[14] Further, while these goals have been identified separately, any advancements made towards increasing the percentage of alternative payment models will help towards achieving the overall goal of aligning payments with a quality or value component.[15]

HHS established the *Health Care Payment Learning and Action Network* (HCPLAN) to help with the necessary system transitions to ensure the work performed in one sector is aligned with the progress of another sector, reduce unnecessary duplication of work, and reduce the amount of confusion these changes may cause. HCPLAN will focus on the operational components necessary to successfully implement quality based care measures throughout the system as a whole and not just for the population covered by Medicare payments.[16] Additionally, HCPLAN is responsible for fostering collaboration between HHS, consumers, providers, state and federal partners, private payers, and large employers to help transition advanced payment models, categories 3 and 4, into the market.[17]

HHS Secretary Sylvia Burwell stated that, even with all of the improvements made so far, that many people today are still not receiving quality care as evidenced by one out of every ten hospitalized patients experiencing an adverse event during their episode of care.[18] HHS envisions that by releasing these goals and using payment incentives to foster quality care, it will be able to accelerate the pace of improvements and advance change in a sustainable and permanent manner.[19]

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13 HHS, January 26, 2015 (Accessed 3/12/15).
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19 *Ibid*.

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