Value: the journey from volume to value, good for physicians

This transition is slowly moving from paying physicians and other providers for how much they do, to paying them for quality and outcomes. The changes are very regional, with some regions moving faster than others. Nevertheless, the direction is consistent. What I want to talk about here is why this is good for physicians.

This helps change the focus from simply doing more and getting paid more, to doing the right thing and getting paid more for doing the right thing. Imagine getting paid more for better care and not having to ask," Mother May I" to get a CT scan and other procedures done. Of course this additional control comes with a price. That price is accountability for not just Quality

and outcomes, but also for the efficient use of healthcare resources, IE costs.

Currently payment incentives are dramatically misaligned. The more physicians do the more they get reimbursed, however this excludes many services such as phone calls, discussions with colleagues, charting and many others. Other providers such as hospitals get paid very differently and therefore have very different incentives. This causes conflict.

We must realign these incentives and start paying for better outcomes. In this new model healthcare providers decide what activities are needed to get better outcomes. This will certainly include things such as phone calls, family discussions, and physician-to-physician discussions.

These changes will be incremental initially focusing on pay for performance and/or quality bonuses. These bonuses financially reward quality and outcomes, cost efficiency, utilization efficiency, and patient experience.

Further along the transition continuum to value-based payment is shared savings where payment to the provider is based on sharing any savings on the total cost of healthcare at the patient level. From here models move to various risk arrangements which give the physicians and/or delivery systems payment for groups of services (PMPM or capitation) over time. These can

include full professional risk in which the money covers all physician services, or full risk where the payment covers all healthcare cost of an entire group of patients.

The government Bundling programs are a form of this type of risk where a physician group and/or hospital is paid one fee for a certain diagnosis including three days before the hospitalization and 90 days after the hospitalization. This rewards good outcomes and efficient use of healthcare dollars since any savings is paid back to the providers. Right now, other than CJR (total joints), they are involuntary. Based on CMS comments, I would expect this to change shortly.

One critical piece of this is the concern of providers on "patient engagement". This is a difficult area in which much work is actively going on. Currently there are many programs to reward patients for better health behaviors. As a physician is important to look at not simply your noncompliant patients but your entire population of patients. many of these patients are very compliant. It is important to have a population mind set, and not just look at the outliers

The road will be bumpy over the next several years as the metrics and systems for payment get worked out. Ultimately these new patient models will serve patients and physicians well. Physicians will start being paid for doing the right things and getting the right outcomes.

This will help align incentives with payment models and support good care using healthcare resources wisely.
No easy task.