All the talk about moving healthcare reimbursement from volume to value sounds great, in theory. But how this shift takes place in practice is more complex than simply ending one form of payment and starting a new one.

Take, for example, the idea of a hospital forming an accountable care organization (ACO) with a physician group. Such an ACO could be paid for value by improving care quality delivered to groups of patients. But consultants Purdue Healthcare Advisors showed that almost half (46 percent) of hospital administrators responding to a recent survey have "no plans to implement an ACO in the near future."

Among this "no plans" group, 52 percent said there were too many unknowns about ACOs; they wanted more evidence of success. Others (49 percent) said their facilities were too small, and about a quarter (26 percent) said the financial investment outweighed the potential return. All are valid concerns because, as the survey suggested, moving from volume to value is complicated. But in the meantime, health plans, physicians, and other hospitals are developing ACOs or at least starting to get paid based on improving patient outcomes or hitting certain quality targets. By doing so, these ACOs are creating new competitors for the "no plans" group. These two trends—the formation of new partnerships and the changes in how hospitals are paid—signify that the market has entered "an era of big transition, as Marc Manley, MD, describes it. Manley is the vice president, population health management for the Insurance Services Division at the University of Pittsburgh Medical Center, which has had its own health insurance division since 1997.

“Fortunately, it’s a transition that will take place over a number of years, giving hospitals time to adapt to delivering population health,” Manley adds. “But the bad news is that we’re operating two
systems at the same time: Payment is still being done on volume while some reward is being offered for delivering higher value care and cost savings.”

Although hospitals have reasons to pursue volume-based reimbursement, they may be operating against the prevailing marketplace trends. “Many hospitals still believe that getting more people into the ER is a good thing financially,” Manley says. “But payers don’t agree. That’s a sign that the financial incentives are not aligned. The physicians may already realize that they could offer longer clinic hours instead of forcing patients to use the ER. That’s another sign that incentives are misaligned.”

Perhaps it’s time for hospitals to seek new ways to collaborate with payers, Manley adds. “Hospitals could ask about sharing data with payers and about sharing savings and eventually ask about sharing the risk too. Once you do that, you can work out the details contractually. The bottom line is there needs to be much less distance between these two kinds of organizations,” he says.

At first, hospitals may struggle to align the financial incentives because doing so will require adopting new skills to limit bed days and procedure volume. “Hospitals need to understand financial risk the way that actuaries understand it, and they need to understand the level of illness in the population, how patients are getting care, and where care is being delivered that is inefficient or not effective,” Manley advises.

Actuaries understand how to measure risk and adjust for different levels of illness in a population. “Most hospitals begin by defining who their patients are. But a better question to ask is: Who do your payers think you’re responsible for? What are their expectations? Does the hospital have data or does the health plan have data that it can share with the hospital?” he asks.

It’s not uncommon for hospitals to insure their own employees and family members and then introduce innovative strategies to this population. WellSpan, an integrated delivery system of three hospitals in York and Adams counties in Pennsylvania, has a program to identify high utilizers in York and Gettysburg. High utilizers are those top 5 percent of a population that account for almost half (49.9 percent) of total healthcare spending, according to a report this summer from the federal Agency for Healthcare Research and Quality. Being self-insured, WellSpan will reap some benefit from lower use of health services among its own workers and dependents.

The point is that hospitals should be fostering such changes in the marketplace. They should not have to learn from the ER that patient volume has declined because the largest physician group is developing an ACO with a national insurer. And they certainly don’t want to see bed days drop because a health plan is managing care efficiently when there’s no arrangement for payment for value.