
July 2023

# The Transition from Volume to Value in the Provision of Healthcare Services

The transition from volume to value in the provision of healthcare services, alongside increases in co-management arrangements between hospitals and physicians, has led to increases in quality of care.

Over the past several decades, there has been a broad shift from volume-based models to value-based models in the United States healthcare industry.[1] Under the volume-based or fee-for-service model that previously dominated the healthcare industry, providers were generally compensated at fixed rates based solely on the type and total volume of services performed.[2] With fee-for-service healthcare provision, doctors had little to no incentive to limit unnecessary tests and procedures, as their compensation increased with the volume of services provided (hence a "volume-based" system).[3] This led to undue waste, medical cost bloat, and suboptimal patient outcomes.[4] Because physicians' and hospitals' compensation are not tied to patient outcomes, volume-based systems often result in a lack of focus on quality care and a lack of accountability for providers.[5] Patients may receive too much or too little care because the financial incentives

[1] *See, e.g.*, Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (Dec. 2, 2020) at 77493-96; Vennaro, Nick. "Value-Based Care: Past, Present, and Future." *Healthcare Financial Management Association* (June 5, 2017). <https://www.hfma.org/topics/blog/54494.html>.

[2] *See* "What Is Value-Based Healthcare?" *New England Journal of Medicine Catalyst* (Jan. 1, 2017). <https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558>; Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (Dec. 2, 2020) at 77493.

[3] *See, e.g.*, Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (Dec. 2, 2020) at 77496 (stating that "the physician self-referral law was enacted [in 1989] at a time when the goals of the various components of the health care system were often in conflict, with each component competing for a bigger share of the health care dollar without regard to the inefficiencies that resulted for the system as a whole—in other words, a volume-based system.").

[4] *See* Shrank, William H., Teresa L. Rogstad, and Natasha Parekh. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." *JAMA* 322.15 (2019): 1501-1509 at 1506-07; Hunter, Kaitlin, David Kendall, and Ladan Ahmadi. "The Case Against Fee-for-Service Health Care." *Third Way* (Sept. 9, 2021). <https://www.thirdway.org/report/the-case-against-fee-for-service-health-care>; Lockner, Anne M. "Insight: The Healthcare Industry's Shift from Fee-for-Service to Value-Based Reimbursement." *Bloomberg Law* (Sept. 26, 2018). <https://news.bloomberglaw.com/health-law-and-business/insight-the-healthcare-industrys-shift-from-fee-for-service-to-value-based-reimbursement>.

[5] Lockner, Anne M. "Insight: The Healthcare Industry's Shift from Fee-for-Service to Value-Based Reimbursement." *Bloomberg Law* (Sept. 26, 2018). <https://news.bloomberglaw.com/health-law-and-business/insight-the-healthcare-industrys-shift-from-fee-for-service-to-value-based-reimbursement>;

make some tests or procedures more attractive to perform than others.[6] Volume-based payment models also do not incentivize low-cost, high-value services like preventative care.[7]

Under value-based healthcare, healthcare organizations aim to maximize "value," or healthcare outcomes per dollar spent.[8] This is meant to achieve better care at lower costs, benefitting both patients and payors.[9] In practice, this means that provider compensation rewards physicians for achieving favorable patient outcomes, as well as for implementing cost-saving or efficiency-boosting measures.[10]

The movement towards value-based healthcare models gained traction throughout the 1990s and 2000s as the industry and the public paid increasing attention to skyrocketing medical costs, and as desire grew to incentivize and reward favorable patient outcomes.[11] The model is perhaps best encapsulated by the Institute for Healthcare Improvement's "Triple Aim": "[i]mproving the patient experience of care (including quality and satisfaction); [i]mproving the health of populations; and [r]educing the per capita cost of health care."[12]

In pursuit of these same aims, federal agencies such as CMS have implemented numerous regulatory changes to incentivize value-based care.[13] For example, CMS instituted the Hospital Readmission Reduction Program in 2012 to incentivize healthcare providers to reduce excess readmissions after initial treatment by reducing CMS payments to hospitals that perform poorly on this metric.[14] The Department of Health and Human Services has also recognized the positive effect of value-based healthcare models with its "Regulatory Sprint to Coordinated Care," an

---

Hunter, Kaitlin, David Kendall, and Ladan Ahmadi. "The Case Against Fee-for-Service Health Care." *Third Way* (Sept. 9, 2021). <https://www.thirdway.org/report/the-case-against-fee-for-service-health-care> at 5.

[6] Hunter, Kaitlin, David Kendall, and Ladan Ahmadi. "The Case Against Fee-for-Service Health Care." *Third Way* (Sept. 9, 2021). <https://www.thirdway.org/report/the-case-against-fee-for-service-health-care> at 5-7.

[7] Lockner, Anne M. "Insight: The Healthcare Industry's Shift from Fee-for-Service to Value-Based Reimbursement." *Bloomberg Law* (Sept. 26, 2018). <https://news.bloomberglaw.com/health-law-and-business/insight-the-healthcare-industrys-shift-from-fee-for-service-to-value-based-reimbursement>.

[8] *See* "What Is Value-Based Healthcare?" *New England Journal of Medicine Catalyst* (Jan. 1, 2017). <https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558> ("The 'value' in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.").

[9] *See* "Better Health at Lower Costs: Why We Need Value-Based Care Now." *Aetna* (2019). <https://www.aetna.com/employers-organizations/resources/value-based-care.html>.

[10] *See* "What Is Value-Based Healthcare?" *New England Journal of Medicine Catalyst* (Jan. 1, 2017). <https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558>.

[11] *See* Harrill, Willard C. and David E. Mellon. "A Field Guide to U.S. Healthcare Reform: The Evolution to Value-Based Healthcare." *Laryngoscope Investigative Otolaryngology* 6.3 (2021): 590-599.

[12] "The IHI Triple Aim." *Institute for Healthcare Improvement*. <https://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx>. *See also* Teisberg, Elizabeth, Scott Wallace, and Sarah O'Hara. "Defining and Implementing Value-Based Health Care: A Strategic Framework." *Academic Medicine* 95.5 (2020): 682-685 at 683 ("Value-based health care is a path to achieving the aspirational goals of the Institute for Healthcare Improvement's 'triple aim[.]'").

[13] "Value-Based Programs." *Centers for Medicare & Medicaid Services* (Mar. 31, 2022). <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs>.

[14] "Hospital Readmissions Reduction Program (HRRP)." *Centers for Medicare & Medicaid Services* (Aug. 8, 2022). <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program>.

initiative to examine and remove regulatory barriers to value-based care systems that involved revisions to both the AKS and the Stark Law in late 2020.[15] The Regulatory Sprint recognized that co-management arrangements and other value-based payment arrangements had already been occurring for many years and that this should be encouraged to continue, while also recognizing that the regulatory burden of maintaining these programs was high.[16] As part of these revisions, multiple new AKS safe harbors and Stark Law exceptions were created to protect value-based arrangements and remove regulatory impediments, including an AKS safe harbor protecting "outcomes-based payments" between or among a principal and agent rewarding one party for achieving evidence-based healthcare quality goals.[17] Healthcare organizations themselves have also been modernizing their internal structures in pursuit of these value-based care goals.[18]

The effects of this shift to value-based care have been numerous and generally positive. Patient health outcome measures have improved at numerous facilities after the implementation of value-based care systems.[19] While medical costs are still high overall in the United States, the value-based healthcare model has been instrumental in reducing financial waste across multiple settings.[20] Perhaps due to this success, the shift towards this model is still actively accelerating and evolving nationwide, with more and more healthcare organizations transitioning to value-based systems, and with new ideas being tested and implemented constantly.

As part of the industry-wide transition to value-based care, hospitals have looked for ways to ensure physician engagement with patient outcomes and hospital success. One major way that the industry has achieved this goal is through co-management arrangements in which hospitals collaborate with physicians as stakeholders. Co-management arrangements take many forms, but

---

[15] Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (Dec. 2, 2020) at 77493, 77496; "A Brief Summary of the Stark Law and Anti-Kickback Statute Reforms (Final Rules)." *American Medical Association* (Dec. 2, 2020). <https://www.ama-assn.org/system/files/2020-12/stark-law-aks-summary-final-rules.pdf> at 1.

[16] *See* Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (Dec. 2, 2020) at 77493-94 ("Since the enactment of the physician self-referral statute in 1989, significant changes in the delivery of health care services and the payment for such services have occurred[.] … Commercial payors and health care providers have implemented and continue to develop numerous innovative health care payment and care delivery models[.] … [CMS has] a goal of reducing regulatory burden and dismantling barriers to value-based care transformation while also protecting the integrity of the Medicare program.").

[17] Eiler, Richard, et al. "CMS and the OIG Issue Final Rules Modernizing and Clarifying the Federal Stark and Anti-Kickback Laws." *Bass, Berry & Sims* (Dec. 2020). <https://www.bassberry.com/wp-content/uploads/stark-anti-kickback-aks-final-rules-2020.pdf> at 3, 19-20.

[18] *See, e.g.*, "Better Health at Lower Costs: Why We Need Value-Based Care Now." *Aetna* (2019). <https://www.aetna.com/employers-organizations/resources/value-based-care.html> at 12.

[19] *See, e.g.*, Teisberg, Elizabeth, Scott Wallace, and Sarah O'Hara. "Defining and Implementing Value-Based Health Care: A Strategic Framework." *Academic Medicine* 95.5 (2020): 682-685 at 683 ("Improving value in health care is not an unreachable utopian ideal. Around the globe, health care delivery organizations—in varied payment settings, with an array of regulatory structures and many different care traditions—have demonstrated dramatically better health outcomes for patients, usually at lower overall costs.").

[20] *See id.*; Shrank, William H., Teresa L. Rogstad, and Natasha Parekh. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." *JAMA* 322.15 (2019): 1501-1509 at 1506-07.

generally involve partnerships between healthcare providers (e.g., doctors) and healthcare entities (e.g., hospitals) to share responsibility for patient care in order to maximize efficiency and value.[21]

For example, a common co-management arrangement involves the creation of a management company, jointly owned by a hospital and one or more physicians, which contracts with the hospital to assist with managing a specific service line.[22] Physicians focus on the clinical aspects of the service line, including collaborating with the hospital to manage and improve the quality and efficiency of the service line, while the hospital provides the administrative services necessary to facilitate delivery of the service line.[23]

This type of arrangement, and indeed co-management arrangements in general, have been instrumental in the value-based healthcare transition by allowing doctors to have direct engagement with patient care. Often, the physicians are paid an incentive payment that is directly tied to patient health outcome metrics, such as hospital re-admission rates.[24]

These agreements have been rising in popularity because they work.[25] In fact, a survey by the Healthcare Financial Management Association found that as of 2013, 30 percent of hospitals and health systems planned to increasingly pursue clinical co-managements, directorships, or other professional arrangements.[26] From an economic perspective, quality-based co-management arrangements ensure that the physician's incentives are aligned with the best interests of the patient, meaning both the physician and patient have an interest in the patient receiving high-quality and high-value care.[27] They can also create valuable operational efficiencies. Physicians

---

[21] *See* Sabis, Chris, Tracy Powell, and Micah Bradley. "Co-management Agreement Pitfalls and Best Practices: A Case Study." *Compliance Today* (Mar. 2022). <https://compliancecosmos.org/co-management-agreement-pitfalls-and-best-practices-case-study>.

[22] *See, e.g.*, Breuer, Jennifer and John D'Andrea. "The Law Review: Structuring Co-management Agreements." *Advisory Board* (Nov. 10, 2011). <https://www.advisory.com/Daily-Briefing/2011/11/10/Law-Review-Considerations-in-structuring-co-management>.

[23] *See* Sabis, Chris, Tracy Powell, and Micah Bradley. "Co-management Agreement Pitfalls and Best Practices: A Case Study." *Compliance Today* (Mar. 2022). <https://compliancecosmos.org/co-management-agreement-pitfalls-and-best-practices-case-study>.

[24] *See, e.g.*, Breuer, Jennifer and John D'Andrea. "The Law Review: Structuring Co-management Agreements." *Advisory Board* (Nov. 10, 2011). <https://www.advisory.com/Daily-Briefing/2011/11/10/Law-Review-Considerations-in-structuring-co-management>; Werling, Kristian, Holly Carnell, and Melissa Szabad. "Regulatory Considerations for Structuring Physician/Hospital Co-Management Agreements." *Health Care Law Monthly* (2010): 2-6 at 2.

[25] *See, e.g.*, Werling, Kristian, Holly Carnell, and Melissa Szabad. "Regulatory Considerations for Structuring Physician/Hospital Co-Management Agreements." *Health Care Law Monthly* (2010): 2-6 at 2 ("Co-management arrangements are becoming an increasingly popular model for aligning incentives between physician groups and hospitals, specifically in the context of high-cost service lines such as cardiology and orthopedics.").

[26] "Executive Survey on Hospital-Physician Affiliation Strategies." *Healthcare Financial Management Association* (Apr. 2013). <https://www.hfma.org/topics/research_reports/17709.html> at 6. As of early 2014, about 14 percent of senior hospital executives reported that they were actively engaged in co-management strategies. "Strategies for Physician Engagement and Alignment." *Healthcare Financial Management Association* (Nov. 2014) at 3.

[27] This is also openly acknowledged in the industry. *See, e.g.*, Werling, Kristian, Holly Carnell, and Melissa Szabad. "Regulatory Considerations for Structuring Physician/Hospital Co-Management Agreements." *Health Care Law Monthly* (2010): 2-6 at 2; Breuer, Jennifer and John D'Andrea. "The Law Review: Structuring Co-management Agreements." *Advisory Board* (Nov. 10, 2011). <https://www.advisory.com/Daily-Briefing/2011/11/10/Law-Review-Considerations-in-structuring-co-management> ("Due to health care

who are stakeholders in the outcomes of their medical practice have a direct personal interest in reducing financial inefficiencies and effecting real improvements in service lines.

Operational efficiencies are valuable to all parties, and under value-based care models efficiency and quality go hand-in-hand. For instance, CMS's quality measures webpage describes "efficient" care as part of its overarching quality goals.[28] Efficiency is also one of the three prongs of the Triple Aim,[29] and indeed the entire premise of value-based care is "better health at lower costs."[30] Further, payors generally have an interest in encouraging efficiency to the extent it leads to a reduction in costs to the payor while maintaining quality of patient care.[31]

In addition to being popular and effective at optimizing efficiency and quality, co-management arrangements have been widely developed and used throughout the healthcare industry in a manner that does not provide kickbacks or self-referrals or that aligns with the exception or safe harbor requirements of the physician referral regulations.[32] For instance, co-management agreements generally provide that compensation must be determined in advance and be consistent with fair market value from arms-lengths transactions.[33] One way this can be accomplished is by having specific compensation formulas that are set in advance by the contractual arrangement.[34] Such arrangements, when properly structured, are well understood in the industry and by CMS regulators to be permissible.[35]

---

reform and accountable care, many hospitals are seeking opportunities to align physician interests with hospital programmatic, quality of care and patient satisfaction initiatives. Co-management arrangements are an important addition to the arsenal of hospital-physician alignment tools[.]").

[28] "Quality Measures." *Centers for Medicare & Medicaid Services* (Apr. 14, 2022). <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures>.

[29] "The IHI Triple Aim." *Institute for Healthcare Improvement*. <https://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx>.

[30] *See* "Better Health at Lower Costs: Why We Need Value-Based Care Now." *Aetna* (2019). <https://www.aetna.com/employers-organizations/resources/value-based-care.html>.

[31] Teisberg, Elizabeth, Scott Wallace, and Sarah O'Hara. "Defining and Implementing Value-Based Health Care: A Strategic Framework." *Academic Medicine* 95.5 (2020): 682-685 at 682 ("Improving a patient's health outcomes relative to the cost of care is an aspiration embraced by stakeholders across the health care system, including patients, providers, health plans, employers, and government organizations. Value-based health care aligns these diverse parties' goals so well that, shortly after the concept was introduced in 2006, health economist Uwe Reinhardt described it as 'a utopian vision.'").

[32] *See, e.g.*, Werling, Kristian, Holly Carnell, and Melissa Szabad. "Regulatory Considerations for Structuring Physician/Hospital Co-Management Agreements." *Health Care Law Monthly* (2010): 2-6; Breuer, Jennifer and John D'Andrea. "The Law Review: Structuring Co-management Agreements." *Advisory Board* (Nov. 10, 2011). <https://www.advisory.com/Daily-Briefing/2011/11/10/Law-Review-Considerations-in-structuring-co-management>; Sabis, Chris, Tracy Powell, and Micah Bradley. "Co-management Agreement Pitfalls and Best Practices: A Case Study." *Compliance Today* (Mar. 2022). <https://compliancecosmos.org/co-management-agreement-pitfalls-and-best-practices-case-study>.

[33] *See* Werling, Kristian, Holly Carnell, and Melissa Szabad. "Regulatory Considerations for Structuring Physician/Hospital Co-Management Agreements." *Health Care Law Monthly* (2010): 2-6 at 2.

[34] *See, e.g.*, Safriet, Scott and Kris Werling. "The Evolution of Service Line Co-Management Relationships with Physicians - Key Observations on Relationships and Fair Market Value." *McGuire Woods*. <https://www.beckershospitalreview.com/pdfs/conference/14_Safriet_Werling_%20Co-Management_Arrangements_in_Healthcare.pdf> at 6, 10, 13.

[35] *See id.*; Sabis, Chris, Tracy Powell, and Micah Bradley. "Co-management Agreement Pitfalls and Best Practices: A Case Study." *Compliance Today* (Mar. 2022). <https://compliancecosmos.org/co-management-agreement-pitfalls-and-best-practices-case-study>.

## Featured Expert: Professor Louis F. Rossiter

Professor Lou Rossiter was recently retained by a healthcare provider that manages services in medical centers to opine on the regulatory landscape surrounding physician referrals, the evolution of hospital remuneration and incentivization systems, as well as relevant co-management agreements.

Professor Rossiter is a Research Professor in the Public Policy program at the College of William & Mary. He previously served as Senior Policy Advisor to the Administrator of the CMS. In that role, he led the CMS team working with the OIG in its development of the Medicare and State Health Care Programs: Fraud and Abuse: Anti-Kickback Provisions (July 29, 1991)(56 Fed. Reg. 35952), which promulgated the 10 original safe harbor provisions.

**For additional inquiries or retaining Professor Rossiter, please contact** experts@vegaeconomics.com.