Why Volume-Based Payment Is Running Out of Road

The can we kept kicking has reached the end of the road

By William Breen, DSc, FACHE · The Healthcare Fix · thehealthcarefix.com

In 2020, I wrote in *Memphis Medical News* that I sensed a great deal of cans being kicked down the road on value. It might sound like a hospital saying, “Well, I agree, but until the incentives change, I'm going to keep working to acquire volume.” Or a doctor saying, “I need to change, but I'm retiring in a few years. I won't have to deal with much of that.”

Six years later, I believe the road is running out. Not because anyone gave a speech about value, but because the math behind volume no longer works.

Volume without a check

Let me be plain about the problem. Volume without the check of value leads to unnecessary cost and lower quality. A system that pays for each thing done lacks the incentives to raise expectations. It has no reward for being accountable beyond the four walls of the facility: for the patient who goes home, fills the prescription, keeps the follow-up visit and stays out of the emergency room. Once the patient walks out the door, volume stops paying attention.

Sign one: each unit pays less

Volume-based payment works when each visit, test or procedure pays enough to cover its cost. That is no longer true for physicians in Medicare. The American Medical Association reports that from 2001 to 2026, the cost of running a medical practice rose 63 percent while Medicare physician payment rose only 10 percent. Adjusted for practice cost inflation, physician payment fell 33 percent.

When the price of each unit keeps shrinking, the only volume strategy left is to run faster. More visits, shorter visits, more staff time chasing claims. That is not a strategy. It is a treadmill, and it is a big part of why so many good physicians are tired.

Sign two: the biggest payer is running short

In June, the Medicare Trustees projected that the Hospital Insurance trust fund, which pays for inpatient care, will be depleted in the second quarter of 2033. At that point, unless Congress acts, Medicare could pay only about 89 percent of scheduled hospital benefits, an 11 percent cut.

Congress will likely act before then. But any fix will push in one direction: paying for results rather than for activity. A growth plan built on more Medicare admissions is a plan built on the part of the system with the least room left.

Sign three: the money is already moving

This is not a forecast. Nearly half of U.S. health care payments, 44.9 percent in 2024, now flow through alternative payment models tied to cost and quality, and 28.7 percent involve downside risk, according to the national measurement effort now led by AHIP with CMS.

Washington is planning for the long term, too. CMS's new Long-term Enhanced ACO Design model, called LEAD, launches January 1, 2027, and runs for ten years, through 2036. It is the longest accountable care model CMS has ever tested, and it is designed to bring in small, independent and rural practices that have stayed on the sidelines. When CMS commits to a decade, it is telling you where the road goes next.

Why volume still feels safe

I understand the hesitation. Fee-for-service still pays most of the bills. Value-based contracts can be complicated, and benchmarks and rules change. Models come and go; ACO REACH itself ends this year. A small practice can reasonably ask why it should take risk when it can barely keep up with today's work.

But the real risk is not moving too early. It is moving last. The skills value-based care requires take years to build: knowing your patients' total cost of care, managing the sickest few, coordinating with specialists, and negotiating contracts on value instead of rates. Organizations that start learning now will be ready when the money moves the rest of the way. Organizations that wait will be learning under pressure.

What replaces volume

I believe value-based care is the only model that lines up the incentives of those who pay for care and those who deliver it. When both sides gain from keeping people healthy, the sustainable choice and the patient-serving choice become the same choice. And the people closest to the visit, physicians and their practices, are in the best position to lead.

What to do Monday morning

Start with four steps. Learn your patients' total cost of care, not just your revenue per visit. Choose one value-based contract to learn on, whether a Medicare ACO or a commercial shared savings arrangement. Identify the small group of patients who drive most of your cost and build care coordination around them. And add one value measure to how you define growth, alongside visits.

Then test every step with my two questions. Does it serve the patient? Can it keep doing so?

If you are deciding where to start, I would welcome the conversation. My goal is to help you become your own best consultant before the road runs out.

When it seems crazy out there, and it sometimes is, remember that the patient is still a reliable true north. The new road leads there.

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