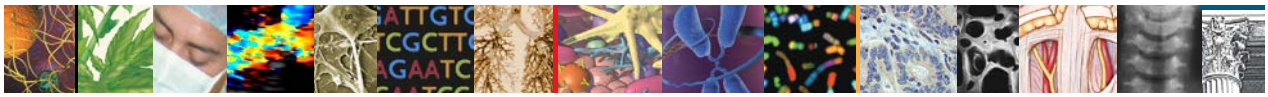

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Perspective

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

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Now that the Affordable Care Act (ACA) has expanded health care coverage and made it affordable to many more Americans, we have the opportunity to shape the way care is delivered and improve the quality of care systemwide, while helping to reduce the growth of health care costs. Many efforts have already been initiated on these fronts, leveraging the ACA's new tools. The Department of Health and Human Services (HHS) now intends to focus its energies on augmenting reform in three important and interdependent ways: using incentives to motivate higher-value care, by increasingly tying payment to value through alternative payment models; changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and harnessing the power of information to improve care for patients.

As we work to build a health care system that delivers better care, that is smarter about how dollars are spent, and that makes people healthier, we are identifying metrics for managing and tracking our progress. A majority of Medicare fee-for-service payments already have a link to quality or value. Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment models include accountable care organizations (ACOs) and bundled-payment arrangements under which health care providers are accountable for the quality and cost of the care they deliver to patients. This is the first time in the history of the program that explicit goals for alternative payment models and value-based payments have been set for Medicare. Changes assessed by these metrics will mark our progress in the near term, and we are engaging state Medicaid programs and private payers in efforts to make further progress toward

value-based payment throughout the health care system. Through Healthy People 2020 and other initiatives, we will also track outcome measures that reflect changes in Americans' health and health care.

To drive progress, we are focusing on three strategies. The first is incentives: a major thrust of our efforts is to create an environment in which hospitals, physicians, and other providers are rewarded for delivering high-quality health care and have the resources and flexibility they need to do so. The ACA creates a number of new institutions and payment arrangements intended to drive the health care system in this direction. These include alternative payment models such as ACOs, advanced primary care medical-home models, new models of bundling payments for episodes of care, and demonstration projects in integrated care for beneficiaries dually eligible for Medicare and Medicaid.

Looking ahead, we plan to develop and test new payment models for specialty care, starting with oncology care, and institute payments to providers for care coordination for patients with chronic conditions. Three years ago, Medicare made almost no payments through these alternative payment models,[1] but today such payments represent approximately 20% of Medicare payments to providers, and as noted above, we aim to increase this percentage. As part of this work, we also recognize the need to continue to reach consensus on the quality measures used and address issues related to risk adjustment in these new models.

Second, improving the way care is delivered is central to our reform efforts. We have put in place policies to encourage greater integration within practice sites, greater coordination among providers, and greater attention to population health. Through the Partnership for Patients, we have engaged U.S. hospitals in learning networks to focus on high-priority risks to patient safety and have already seen significant improvement. There is now a national program to reduce hospital readmissions within 30 days after discharge, which encourages hospitals to improve transitional care and coordinate more effectively with ambulatory care providers. Readmission rates are decreasing nationwide.[2] Through the Transforming Clinical Practice Initiative, we will invest up to $800 million in providing hands-on support to 150,000 physicians and other clinicians for developing the skills and tools needed to improve care delivery and transition to alternative payment models. New Medicaid health homes, patient-centered medical homes, and efforts to reorganize care for people eligible for both Medicare and Medicaid are all designed to foster greater integration and coordination.

Third, we aim to accelerate the availability of information to guide decision making. The Obama administration has led a major initiative in health information technology (IT), focusing on the adoption of electronic health records (EHRs) and their meaningful use as a central avenue for transforming care. The proportion of U.S. physicians using EHRs increased from 18% to 78% between 2001 and 2013, and 94% of hospitals now report use of certified EHRs.[3] Ongoing efforts will advance interoperability through the alignment of health IT standards and practices with payment policy so that patients' records are available when needed at the point of care to permit informed clinical decisions to be made in a timely fashion.

HHS has made a commitment to enhancing transparency in the health care market. For example, the Medicare website enables consumers to compare data on the costs and charges for hundreds of inpatient, outpatient, and physician services. Information is available on the quality of hospitals, physicians, nursing homes, and other providers, enabling consumers to make better-informed choices when selecting providers and health plans.

The ACA established the Patient-Centered Outcomes Research Institute (PCORI), dedicated to generating information that can guide doctors, other caregivers, and patients as they address important clinical decisions; PCORI is working with the Agency for Healthcare Research and Quality to disseminate this information. In the years ahead, the research findings from PCORI, disseminated in part through EHRs, can bring critical clinical information to providers and patients when they need it most, at the point of care.

Although we have much to celebrate regarding increased access and quality and reduced cost growth, much of the hard work of improving our health care system lies ahead of us. Care delivered in hospitals was much safer in 2013 than it was in 2010: there were 1.3 million fewer adverse events between 2011 and 2013 than there would have been if the rate of such events had remained unchanged, and an estimated 50,000 deaths were avert-

ed. Still, far too many hospitalized patients — nearly 1 in 10 — have adverse events while hospitalized, and many people do not receive care that they should receive, while others receive care that does not benefit them. Growth of health care spending is at historic lows: Medicare spending per beneficiary increased by approximately 2% per year from 2010 to 2014 — a rate far below both historical averages and the growth rate of the gross domestic product.[4] Survey data show that more than 7 in 10 people who signed up for insurance in the new health insurance marketplace last year say the quality of their coverage is excellent or good.[5] However, it will take additional effort to sustain and augment the positive changes we have seen so far.

We are dedicated to using incentives for higher-value care, fostering greater integration and coordination of care and attention to population health, and providing access to information that can enable clinicians and patients to make better-informed choices. We believe that, by working in partnership across the public and private sectors, we can accelerate these improvements and integrate them into the fabric of the U.S. health system.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org

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