NATIONAL QUALITY STRATEGY
Better Care. Healthy People/Healthy Communities. Affordable Care.

PRIORITIES IN FOCUS

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Making Quality Care More Affordable

HEALTH AND HEALTH CARE EXPENDITURES CURRENTLY ACCOUNT FOR 17.5 PERCENT OF THE UNITED STATES ECONOMY

THE ISSUE: MAKING QUALITY CARE MORE AFFORDABLE

In 2014, annual health and health care expenditures in the United States reached $3 trillion and accounted for 17.5 percent of the Nation's gross domestic product.[1] Health expenditures have historically grown faster than the rest of the economy, leading to an increase in the national debt, a decrease in the funds available for other public investments, and an increase in business and household budgets.

Numerous studies estimate that roughly 30 percent of health care spending includes expenses for unnecessary services, excess administrative costs, and inefficient delivery, producing little net value to the system in the form of improved health outcomes.[2,3] Fee-for-service payment models, which reward providers based on the quantity of services provided rather than the quality of care and patient outcomes, can, in many cases, result in higher costs and poorer outcomes. Reforming the country's current payment and care delivery systems to address these problems presents enormous opportunities to reduce the cost of care and increase quality of care and the health of populations.

THE NATIONAL QUALITY STRATEGY SOLUTION

The National Quality Strategy calls all stakeholders to make quality care more affordable across the health care system by focusing on two long-term goals:

- Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status; and
- Establish shared accountability and integration of communities and health care systems to improve the quality of care and reduce health disparities.

Tying reimbursements of medical care to value or quality holds promise to improve the quality of care while reducing cost. Paying providers for outcomes achieved rather than services performed incentivizes providers to improve the health of their populations and experiment with delivery models. Encouragingly, the Catalyst for Payment Reform noted a strong trend toward value-based payment models: 40 percent of commercial in-network payments were tied to value or quality in some way in 2014, up from 11 percent in 2013.[4] The public sector echoes this trend: in 2014, 60 percent of Medicare payments were tied to quality, and about 20 percent of Medicare payments were made in alternative payment models.[5] Alternative payment models are formed to improve health and health care while lowering costs through payment and delivery reform, population health management, and care coordination. Examples of alternative payment models include accountable care organizations (ACOs), bundled payments, and patient-centered medical homes. The U.S. Secretary of Health and Human Services set aggressive targets to

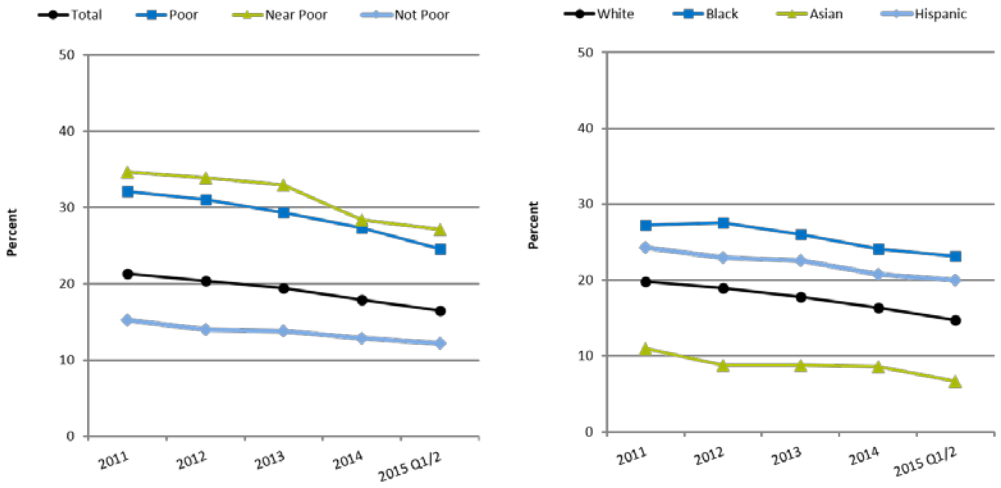
IN 2014, 60 PERCENT OF MEDICARE PAYMENTS WERE TIED TO QUALITY

advance the trend of increasing alternative payment models, calling for 30 percent of Medicare payments to be made in alternative payment models by 2016, and 50 percent by 2018. Additionally, 85 percent of all Medicare fee-for-service payments will be tied to quality or value by 2016 and 90 percent by 2018. These Delivery System Reform goals build on the work across the Nation to make quality care more affordable and transition to value-based, person-centered care.[6]

WHERE WE ARE NOW: 2015 CARE AFFORDABILITY CHARTBOOK

The AHRQ 2015 National Healthcare Quality and Disparities Report Chartbook on Care Affordability shows positive trends in care affordability. From 2011 through the first half of 2015, the percentage of people under age 65 in families having problems paying medical bills decreased overall, and for all poverty status and racial/ethnic groups. Early evidence also suggests alternative payment models can improve health while controlling costs. Preliminary findings from the Medicare ACOs that initiated the program in 2012 show promising results, with improvements on 30 of 33 quality measures and total savings of $417 million.[7]

Care Affordability: People under age 65 who were in families having problems paying medical bills in the past year, by poverty status and race/ethnicity, 2011-2015 Q2[8]



Key: Q = quarter.

[1] Centers for Medicare & Medicaid Services. *National Health Expenditure Data: Historical.* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[2] Berwick DM, Hackbarth AD. Eliminating Waste in US Health Care, JAMA 2012;307(14):1513–6.; http://doi.org/ 10.1001/jama.2012.362;

[3] Institute of Medicine. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press. February 2011. http://iom.nationalacademies.org/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx

[4] Catalyst for Payment Reform. Forty percent of payment to physicians and hospitals in the commercial sector today is designed to improve quality and reduce waste. September 2014. http://www.catalyzepaymentreform.org/images/documents/scorecard2014release

[5] Press M. CMS Innovation and Health Care Delivery System Reform. April 2015. http://www.allhealth.org/briefingmaterials/1-PRESSPRESENTATION_J9.PDF.

[6] U.S. Department of Health and Human Services. *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value*. http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html

[7] Cavanaugh S. ACOs Moving Ahead. December 2014. http://blog.cms.gov/2014/12/22/acos-moving-ahead/

[8] Cohen RA, Schiller JS. Problems paying medical bills among persons under age 65: early release of estimates from the National Health Interview Survey, 2011-June 2015. Hyattsville, MD: National Center for Health Statistics; 2015. http://www.cdc.gov/nchs/nhis/releases.htm..