Health Affairs Blog

Building A System That Works: The Future Of Health Care

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Nearly a century after Theodore Roosevelt's Bull Moose Party first called for health insurance reform, the United States has made major advances in access, quality, and affordability.

In the six years since President Obama signed the Affordable Care Act (ACA) into law, 20 million more people have health insurance, and, for the first time in our history, more than nine out of every 10 Americans are insured. Growth in both premiums for employer coverage and overall Medicare spending has also slowed. The Centers for Medicare and Medicaid Services' Actuaries now project that we are on track to spend $2.6 trillion less over the ACA's first decade than was projected without the ACA back in 2010.

Even with this slow down, any increase in costs can be challenging for businesses monitoring expenses or families working through their budgets. That's why stakeholders nationwide have been coming together to reshape the future of health care. Using new advancements in data, medicine, and the tools and resources provided by the Affordable Care Act, institutions across the country are building a health care system that works better for all Americans.

This work has gone on steadily for years — through political turmoil and challenges in the courts. Yet through each challenge, these reforms have endured.

They must continue to endure. The 20 million Americans who gained coverage cannot lose it again. The more than 129 million people with pre-existing conditions do not want to go back to a time when insurers could discriminate against them, or block them from coverage. Eleven million Medicare Part D beneficiaries cannot afford to lose the $2,000 they have each saved, on average, from the law's work to begin closing the "donut hole." The American people do not want to turn back our nation's progress. Improvements need to be made, but they need to build on progress and not take us backwards in terms of access (the number of insured), affordability (costs to individuals, businesses, and taxpayers), and quality (the benefits that are being provided).

As the Obama Administration comes to a close, this piece lays out my vision for the future of health care. I share the steps we have taken to change how we pay for health care, incentivize coordination, and unlock health care data. This is the path forward—a system where innovative actors are putting the patient at the center—and, despite differences in health care, I firmly believe it is a vision on which we can all agree.

The Challenge

For decades, policymakers and health care providers have lamented the shortcomings of our system: tens of millions of uninsured, hundreds of thousands of lives lost due to avoidable errors, and health costs that outpaced the rest of our economy. We have not seen progress in health care access and quality commensurate with our high level of investment.

One of the reasons is the long legacy of fee-for-service, widely understood to be one of the main drivers of health care costs. Experts have compared fee-for-service to paying carpenters by the inch of lumber, or plumbers by the foot of pipe. It's easy to understand why this payment system is inflationary: in a climate where redundancies have no financial downside, paying for the volume of services without regard to outcomes will result in a system that emphasizes the former.

Our nation's doctors and clinicians are bound by a shared commitment to care for their patients, but incentives matter.

Under a fee-for-service system, each visit, screening, and procedure is rewarded while many of clinicians' most important duties—like reviewing lab tests, corresponding with patients, and communicating with other doctors to coordinate care—go uncompensated. One study found that primary care physicians must address more than three dozen urgent uncompensated tasks every day — tasks like discussing a patient's care plan with a specialist, or working with a nurse to address the side effects of a patient's medications.

These barriers to good care frustrate patients, providers, and payers. It's frustration I've seen firsthand, both in the boardroom of a private sector company and when I've travelled during my time as Secretary.

Improving access and quality while reducing cost is not just achievable — it's a national imperative, one we're working on right now, and one future policymakers would be keen to follow.

Delivery System Reform

In the system we seek, providers collaborate to create a coherent care experience. They have the flexibility to innovate, and will be rewarded for quality outcomes that suppress costs. Electronic records inform treatment and reveal patterns in patient health, allowing for preventive rather than reactive measures. And in this system, patients and consumers are actively engaged in their care decisions — they can use their medical records, easily schedule appointments, and understand how best to use their benefits.

To realize this vision, we have been operating under a three-part strategy:

First, we want to change the way we pay, so that we reward the value of care and patient outcomes rather than the quantity of services. Not only are we doing this by directly compensating actions that we know enhance care and drive costs down, but we are also collaborating with private payers and states to test new payment models that can more broadly change practitioner incentive structures.

Next, we want to improve care delivery by promoting coordination, along with prioritizing wellness and prevention. We achieve this by giving health care leaders the flexibility to innovate to benefit their patients. Through new partnerships and lifestyle interventions, our health care system is also taking a more active role in keeping people healthy, not just treating the already sick.

Finally, we want to unlock health care data and information, so that doctors can make the most informed decisions possible and people are empowered to be active participants in their care. Improving the access and portability of health records reduces redundancies and helps prevent avoidable errors.

In our work across each of these three pillars, we rely on a critical tool—the Center for Medicare and Medicaid Innovation (CMMI)—to systematically develop, test, and scale innovative reforms to payment and service delivery models. Designed with input from stakeholders and clinical experts, these models test novel ways to strengthen quality and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

With this tool, and in concert with the private sector, we have moved beyond incremental, fractured steps toward large-scale, strategic change.

Changing The Way We Pay

In January of 2015, the Administration set out to move the Medicare program toward a value-based approach, announcing a clear timeline and set of metrics to do so. Despite a long history of innovation, this was the first time in the history of the Medicare program that an Administration set explicit goals for adopting value-based payment systems.

We met our first goal 11 months ahead of schedule: as of this January, 30 percent of Medicare payments were in alternative payment models. This shift is significant. Before the Affordable Care Act, Medicare paid essentially $0 through these approaches. Today, we're on track to meet our goal of 50 percent by the end of 2018, which we believe will be a tipping point.

The core of our strategy is this: pay directly for actions that we know drive down costs and improve care; test new payment methods that align financial incentives with evidence-based best practices; and encourage providers to take on the challenge of participating in population-based models, where they are fully responsible for the total cost of their patients' care and a full range of outcomes.

A great example of this are Accountable Care Organizations (ACOs), where groups of doctors, nurses, hospitals, and other health care providers agree to assume responsibility for the quality of care and costs of their patients and then share in any resulting savings. Because ACO participants share responsibility for the same patients even if they work in different care settings, they collaborate to improve care through actions such as reducing duplicate testing and coordinating care transitions. By tying the amount of potential savings earned to measurable outcomes, ACOs' financial incentives are designed to drive care improvements instead of higher volume. In 2015, Medicare ACOs saved $466 million and resulted in improvements across key quality measures. Over 100 new ACOs have joined in the last year, bringing the total to 477 serving nearly 8.9 million people.

Creating a new framework for providing care is not without its challenges. That's why we've created several generations of ACO design in just five years. As we have gained experience with these models, we have been able to work closely with the ACO community to improve them and address some of the challenges that naturally arise as a program matures. For example, we updated how we set ACO spending targets, so that an ACO is rewarded for efficiency relative to its region, instead of having to indefinitely beat its own past performance.

We are also continuing to test payment models that aim to align incentives across care settings for certain patient conditions, rather than a specific population. CMS has bundled payments to certain providers for years, but today we are developing and implementing bundled payment approaches that encompass longer episodes of care, more clinical services, and multiple clinicians and health care organizations. As just one example, the Comprehensive Care for Joint Replacement model now holds participating hospitals accountable for the costs and quality of care for the full episode of a hip or knee replacement from the time of the surgery through 90 days after hospital discharge. Providers who administer high-value care share in the savings and otherwise share in the costs.

Just as important to the future of payment reform is that we are starting to see similar shifts in the private sector and in states. In October, we joined many of our private and state partners to announce that they have also shifted a significant proportion of their health care payments to flow through alternative payments models in 2015 and expect this number to increase for 2016. Thanks to the efforts of the Health Care Payment Learning and Action Network to track this progress, we know that plans and states that cover approximately 200 million Americans are now spending almost a quarter of their health care dollars through alternative payment models.

An additional, critical piece shaping the future of payment reform is a historic law Congress passed last year — the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). MACRA provided new tools to accelerate the shift from volume to value-based payments like the newly established Quality Payment Program, where Medicare will pay clinicians based on patient outcomes and efficient care. In particular, the law encourages clinicians to participate in high-quality alternative payment models across all sectors of the health care system, moving us even closer to a truly integrated health care system that financially rewards care quality and the patient experience.

Implementing MACRA has just begun, and we know questions will continue to arise regarding whether we have sufficiently tailored the program to support small and rural practices, or whether there are enough alternative payment models available. To address these challenges, we plan to continue working closely with clinicians and patients, listening to their concerns and ideas, and responding to their feedback. MACRA is a significant step forward in reforming Medicare payments, but it is an iterative process. This is just the beginning.

Improving Care Delivery

While we change the structure of payments in our health care system so that we pay for the quality of care and not the quantity of services, we also want to connect clinicians with new tools and programs that make it easier to incorporate care coordination, prevention, and wellness into their work.

If you look across the health care system today, the same services vary significantly in cost and quality at different providers. To close that gap and improve the delivery of care for every provider, we need to help Medicare transition to policies that better reward coordinated, quality care. We also need to provide more opportunities for primary care providers to practice the way they think is best. As one example, we recently launched a new advanced primary care medical home model called Comprehensive Primary Care (CPC+). This model offers up-front primary care payments to allow doctors to deliver care more flexibly, such as providing enhanced access to care out of the office or outside of regular office hours, supported by monthly care management fees that allow primary care doctors and clinicians to spend more time with their patients, serve their patients' needs outside of the office visit, and coordinate with specialists.

At the same time, we are making significant investments in programs and models that encourage health and wellness — all to improve health outcomes and lower costs over the long term. One such model is the Medicare Diabetes Prevention Program, a healthy lifestyle program tested by the YMCA that we expanded earlier this year. The results of this model test were promising: model participants lost about 5 percent of their body weight and had a substantially reduced risk of diabetes. Not only were participants healthier, but Medicare saved money as well — as much as $2,650 over 15 months for each enrollee, more than enough to cover the cost of the program. Because we were able to prove that it works at remarkably low costs, the Medicare Diabetes Prevention Program will be made available to Medicare beneficiaries across the country starting in 2018.

Thanks to these and other efforts, trends across the entire health care system show broad improvements in patient safety and reductions in adverse incidents in the hospital setting. From 2010 to 2014, there were 2.1 million fewer hospital-acquired conditions and 87,000 patients' lives were saved, leading to health care cost savings of an estimated $20 billion. This translates into a national reduction of patient harm by 17 percent between 2010 and 2014.

We know it's a long road ahead. Transforming the delivery of health care is a difficult process. Even the first step of measuring quality is a challenge — constructing valid measures with data from small patient populations can be difficult, and information systems are often not standardized.

That's why we are committed to working with providers to support coordinated care and to reduce the burden of reporting and compliance. Last year we announced $685 million to support clinicians in practice transformation and redesign — the Transforming Clinical Practice Initiative. The funding is awarded to national organizations and health care professional associations, who provide technical assistance and educational materials to clinicians. It is also granted to medical group practices, regional health care systems, and regional extension centers to share quality improvement strategies with and offer peer-to-peer support to primary and specialty physicians.

If we can equip providers with the tools they need to test and develop new ways to provide better care, they can lead us down the road to broader, national improvement.

Unlocking Health Data

All of this progress is only possible with health care data that is seamless and secure. Today, data often can't move from one system to another because of incompatibilities between electronic systems. Even when there aren't technological barriers, health systems sometimes don't want to release the information. Further, given the way we currently pay for care, the flow of health care information doesn't always seem valuable.

In a better health care system, it should be easier for clinicians to track vaccinations or screenings, and easier to give a second opinion. In such a system, patients and providers should be able to see everything that has or hasn't worked for a given condition, so they don't repeatedly start from square one. Easily accessible and portable electronic health records (EHRs) not only help patients move seamlessly between their providers, but they also offer patients the agency to take an active role in their care.

Our vision for health information technology (IT) consists of three goals. First, make sure health IT systems are using common standards so that health care data is portable. Second, change the culture around access to information, so doctors and hospitals recognize that their patients have a right to their own electronic health information. Third, ensure that rules and regulations reflect the principle that data moving simply and securely throughout the health care system is vital for market success.

We have made substantial progress. Since 2008, we have seen a nine-fold increase in hospital adoption of a Basic EHR system, allowing us to make advances in areas like e-prescribing. Today, 96 percent of reported hospitals possess certified EHR technology.

Building on this success, we're continuing to make changes to the EHR Incentive programs and Health IT Certification requirements that reduce the burden for providers and hospitals, streamline reporting, and hold IT developers to a higher standard by requiring more rigorous testing. We also are helping individuals understand their right to access and obtain a copy of their electronic health information through new guidance documents, as well as online FAQs. Individuals can now request their records be sent directly to a third party, and we've placed limits on the kinds of fees that entities who provide the records can charge.

It's important to stay clear-eyed about the difficulties we face in unleashing health data. It is time-consuming and expensive to ensure that different systems are compatible. Changing the culture is easier said than done. And even when data can move more freely, it's not always perfectly accurate or useable.

But these principles are catching on, and our partners across the industry see the value of this open and connected system. In fact, last February, companies that provide 90 percent of electronic health records to U.S. hospitals publicly committed to improve the flow of health information.

With more data, continued support at the federal level, and collaboration across the industry, we can get to a system where unlocked data, in the hands of patients and their doctors, also unlocks better care.

Conclusion

These changes—smarter payments based on outcomes, improved care, and data that can be used by doctors and patients—are transforming health care in America.

Although this Administration will conclude in the next month, I have no doubt that the transformation of our health care system is larger than any one Administration or any one President. Rather, it is a transformation guided by the work of actors at all levels and across the country. The Affordable Care Act may have been an important catalyst, but the changes it set in motion are permanent. And were well overdue. Any attempts to reverse or legislate away this progress will have to grapple with the reality of what our nation has already achieved.

This process was not easy or without its setbacks. Untying the old system is complex work. Not all models are successful, and we have learned along the way. We've learned that true delivery system reform requires the support of clinicians, patients, and payers. We've learned that sometimes it takes longer to see results from new initiatives than we would like. We've learned that states can incubate some of the most innovative ideas; and we have learned that we can support the natural desire of clinicians to improve by helping them share best practices, leading to better care quality for all.

All of this work is worth it, because we all benefit from a system that measures outcomes and rewards value. We all benefit from care that centers on patients and enables them to take a greater role in their health care. And our businesses and the entire economy benefit from a system that is more efficient and more effective.

Thanks to consumers, health care providers, and leaders across industries and in the public and private sectors, we are making strides toward the change our nation needs. Together, we are all building a health care system and market that works better — for businesses and people across our nation.

ASSOCIATED TOPICS: HEALTH PROFESSIONALS, HOSPITALS, ORGANIZATION AND DELIVERY, PAYMENT POLICY, QUALITY
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