

## VIEWPOINT

# Disappointment in the Value-Based Era Time for a Fresh Approach?

**Jose F. Figueroa, MD,  
MPH**

Department of Health Policy and Management, Harvard T. H. Chan School of Public Health, Boston, Massachusetts; and Department of Medicine, Harvard Medical School, Boston, Massachusetts.

**Kathryn E. Horneffer,  
BA**

Department of Health Policy and Management, Harvard T. H. Chan School of Public Health, Boston, Massachusetts.

**Ashish K. Jha, MD,  
MPH**

Department of Health Policy and Management, Harvard T. H. Chan School of Public Health, Boston, Massachusetts; Department of Medicine, Harvard Medical School, Boston, Massachusetts; and Harvard Global Health Institute, Cambridge, Massachusetts.



Viewpoint

## Corresponding

**Author:** Ashish K. Jha, MD, MPH, Harvard Global Health Institute, 42 Church St, Cambridge, MA 02138 (ajha@hsph.harvard.edu).

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**Over the past decade**, there has been a series of national initiatives to improve the quality of care that people in the United States receive, many of which originated from the passage of the Affordable Care Act in 2010. However, the evidence to date suggests these efforts have had limited beneficial effects in the Medicare population. Key programs, such as the Hospital Value-Based Purchasing Program, the Physician Quality Payment Program, and the US Hospital Acquired Condition Reduction Program, have not improved patient outcomes. The Hospital Readmissions Reduction Program initially seemed to have reduced hospital readmissions, but more recent studies suggest that much of the gains may be due to changes in coding, not changes in clinical practice, and it remains controversial.<sup>1</sup> Furthermore, some studies have raised concerns that the policy may be associated with higher mortality rates as hospitals aimed to decrease readmissions among patients who have illnesses that may need

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the care, although other studies have not demonstrated an association between the policy and mortality.<sup>2-4</sup> Two other major efforts, the program on accountable care organizations (ACOs) and bundled payments, have shown promise on reducing costs, but neither has had large effects on quality.<sup>5</sup> Nearly a decade after the Affordable Care Act, the evidence is in and is sobering. It is time to leverage the evidence to take a fresh approach to improving the quality of care for patients in the United States.

Why have these national programs underperformed? Although the causes are multifaceted, one important reason may be that current efforts are too diffuse and fail to target the most important issues for any specific group of patients. Most quality measures have generally targeted individuals based on specific clinical conditions or episodes of care (such as a readmission for heart failure) and not on their most pressing need based on their overall clinical profile. In such instances, these quality measures can work counter to what clinicians and patients prioritize. For instance, high-quality care for a young disabled person with mental illness and heart failure may be very different from high-quality care for a frail older person with heart failure. Yet current efforts fail to differentiate between these 2 types of patients with

heart failure. It has been suggested that value of care may be improved by more specifically tailoring care delivery to the needs of subgroups of patients.<sup>6</sup>

One approach to improving the national efforts is to focus on patients who need a high-quality health care system the most: high-need, high-cost (HN/HC) individuals. Although this is not a new concept, a 2017 report from the National Academy of Medicine (NAM) defined this group as those patients who are among the most expensive, have substantial health care needs, and are particularly vulnerable to poor-quality care.<sup>7</sup> This is a group for whom substantial gains can be made in improving value of care. Because the HN/HC population is diverse, the quality strategy has to be responsive to that diversity. Although there are different frameworks for defining HN/HC populations, in this Viewpoint, we use the framework developed by the NAM and focus on the 3 costliest HN/HC subpopulations identified by their report: (1) patients with advanced illness near the end of life;

(2) frail older adults; and (3) nonelderly disabled patients with serious mental illness. What might a customized quality improvement strategy look like for these patients? This Viewpoint summarizes evidence behind their needs and propose ideas for how the Centers for Medicare & Medicaid Services (CMS) can address improving their care.

### Patients at the End of Life

As individuals near the end of life, where they spend their last days often fails to align with their preferences. Although surveys show that most people would prefer to spend their last days at home, the majority do not.<sup>8</sup> Even though quality initiatives for this population center on palliative care services, CMS should consider a population-level measure that prioritizes these patients' general preferences. One important metric is "healthy days at home," a comprehensive measure of interactions with the health care system developed by the Medicare Payment Advisory Committee that tabulates the risk-adjusted number of days in a certain period that patients are both at home and not actively interacting with the health care system (eg, the emergency department). CMS could track, perhaps for ACOs and Medicare Advantage plans, the number of healthy days at home for patients with advanced illness, thus choosing a metric that would align care with patients' wishes while simultaneously reducing unnecessary utilization.

### Frail Older Adults

Although frail adults older than 65 years make up about 9% of the Medicare population, they represent more

than half of all potentially avoidable hospitalizations.<sup>9</sup> When these patients are admitted, they often fare quite poorly and develop delirium, deconditioning, and adverse events at higher rates than other patients; this sets off a cascade that can include prolonged stays in postacute care facilities, exposing patients to further risks and costs. An important quality strategy for frail older persons would focus on keeping them out of the hospital for potentially avoidable conditions. Key quality measures include tracking hospitalizations, emergency department visits, and observation stays related to ambulatory care-sensitive conditions, which are often preventable when patients have access to high-quality primary care. Although CMS currently does measure hospitalizations for ambulatory care-sensitive conditions among all of its ACO patients, a targeted metric that includes emergency department utilization and observation stays and focuses specifically on frail older patients would be more clinically useful. CMS can hold ACOs, Medicare Advantage plans, and others accountable for this broader metric specifically for their frail older patients.

### Nonelderly Disabled Patients With Serious Mental Illness

Younger patients who qualify for Medicare because of a major disability are often poor, disproportionately experience serious mental illness, incur high costs, and often have poor outcomes.<sup>10</sup> A major contributor to their poor outcomes and spending is the interaction between mental illness and other chronic conditions, like heart failure and diabetes. The presence of mental illness often impairs the ability of patients and health systems to manage care for other chronic conditions. Initiatives for these patients should focus on

better coordination and integration of medical care and mental health services. To track whether these efforts are working, CMS can support programs that integrate primary care and mental health, actively measure how well mental health is being managed, and track potentially excess spending related to acute care services that may be a result of inadequate management of mental illness. One potential strategy for this population is to use patient-reported outcome measures, which can quantify symptoms and functionality into a practical score that is sensitive to changes over time and allow clinicians to better tailor treatments to patients' shifting needs. Although this metric needs further refinement, it is one of the few patient outcomes that may be particularly applicable to mental illness, in which changes in symptoms may be gradual and cannot be easily tracked using biometric markers.

### Conclusions

The US national value-based agenda has been a series of well-intentioned programs that have failed to deliver the kinds of improvements that had been expected. Improving the value of care delivered to patients will require learning from these programs and changing the current approach. A customized rather than diffuse value-based agenda that focuses on patients who have poor health outcomes and high costs and are particularly vulnerable to the adverse effects of low-quality care—as defined by the NAM framework for HN/HC patients—is an important place to start. By prioritizing and incentivizing metrics that reflect the unique needs and preferences of patients, it should be possible to better build a high-quality health system that is responsive to all patients.

#### ARTICLE INFORMATION

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#### REFERENCES

1. Ibrahim AM, Dimick JB, Sinha SS, Hollingsworth JM, Nuliyalu U, Ryan AM. Association of coded severity with readmission reduction after the Hospital Readmissions Reduction Program. *JAMA Intern Med.* 2018;178(2):290-292. doi:10.1001/jamainternmed.2017.6148
2. Gupta A, Allen LA, Bhatt DL, et al. Association of the Hospital Readmissions Reduction Program implementation with readmission and mortality outcomes in heart failure. *JAMA Cardiol.* 2018;3(1):44-53. doi:10.1001/jamacardio.2017.4265
3. Wadhera RK, Joynt Maddox KE, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the

Hospital Readmissions Reduction Program with mortality among Medicare beneficiaries hospitalized for heart failure, acute myocardial infarction, and pneumonia. *JAMA.* 2018;320(24):2542-2552. doi:10.1001/jama.2018.19232

4. Dharmarajan K, Wang Y, Lin Z, et al. Association of changing hospital readmission rates with mortality rates after hospital discharge. *JAMA.* 2017;318(3):270-278. doi:10.1001/jama.2017.8444
5. Colla CH, Fisher ES. Moving forward with accountable care organizations: some answers, more questions. *JAMA Intern Med.* 2017;177(4):527-528. doi:10.1001/jamainternmed.2016.9122
6. Porter ME, Pabo EA, Lee TH. Redesigning primary care: a strategic vision to improve value by organizing around patients' needs. *Health Aff (Millwood).* 2013;32(3):516-525. doi:10.1377/hlthaff.2012.0961

7. National Academy of Medicine. *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health.* Washington, DC: National Academy of Sciences; 2017.

8. Teno JM, Gozalo P, Trivedi AN, et al. Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. *JAMA.* 2018;320(3):264-271. doi:10.1001/jama.2018.8981
9. Figueroa JF, Joynt Maddox KE, Beaulieu N, Wild RC, Jha AK. Concentration of potentially preventable spending among high-cost Medicare subpopulations: an observational study. *Ann Intern Med.* 2017;167(10):706-713. doi:10.7326/M17-0767
10. Joynt KE, Figueroa JF, Beaulieu N, Wild RC, Orav EJ, Jha AK. Segmenting high-cost Medicare patients into potentially actionable cohorts. *Healthc (Amst).* 2017;5(1-2):62-67. doi:10.1016/j.hjdsi.2016.11.002