Value-based care is here to stay. There has been widespread adoption throughout all populations as Medicare paved and continues to pave the way. In January 2015, the Department of Health and Human Services (HHS) and the Centers of Medicare and Medicaid (CMS) adopted a framework that categorizes health care payment according to how providers receive payment to provide care:

Category 1	Category 2
Fee-for-service with no link of payment to quality	Fee-for-service with a link of payment to quality
Category 3	**Category 4**
Alternative payment models built on fee-for-service architecture	Population-based payment

Value-based purchasing includes payments made in categories 2 through 4. Moving from category 1 to category 4 involves two shifts: (1) increasing accountability for both quality and total cost of care and (2) a greater focus on population health management as opposed to payment for specific services.

HHS set a goal to have 30 percent of Medicare payments in alternative payment models (categories 3 and 4) by the end of 2016 and 50 percent in categories 3 and 4 by the end of 2018. Overall, HHS seeks to have 85 percent of Medicare fee-for-service payments in value-based purchasing categories 2 through 4 by 2016 and 90 percent by 2018.

In 2018, the Health Care Payment Learning & Action Network (HCP LAN) conducted an APM Measurement Effort from May to July 2018 accounting for 77 percent of the covered U.S. Population. This measurement effort's results show 59 percent of health care dollars being tied to categories 2 through 4.

There is a continued move away from a fee-for-service system that focuses on volume-based reimbursement, and towards a patient-based, value-centered Alternative Payment Model (APM).

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