HHS Aims to Tie Most Medicare Reimbursements to Quality by 2018

Thursday, January 29, 2015

On January 26, 2015, Health and Human Services (HHS) Secretary Sylvia M. Burwell announced specific goals and a timeline for shifting Medicare reimbursements from the traditional fee-for-service (FFS) model, to a quality or value-based model.[1] This is the first time in Medicare’s history that HHS is setting specific goals for such a shift. Secretary Burwell noted that by moving towards a reimbursement model that rewards quality of care, rather than simply paying for each individual service without evaluating the outcome of such services, that the goals of building a health care system that delivers better care, spends health care dollars more wisely and results in healthier Americans will be realized.

The specific timeline reflecting the value-based shift that HHS is committed to are:

- By end of 2016, 30 percent of traditional FFS Medicare payments will be tied to quality or value through alternative payment models such as Accountable Care Organizations (ACOs) or bundled payment arrangements;
- By 2016, 85 percent of all traditional FFS Medicare payments will be tied to quality or value in general;
- By end of 2018, 50 percent of traditional FFS Medicare payments will be tied to such alternative payment models; and
- By 2018, 90 percent of all traditional FFS Medicare payments will be tied to quality or value through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.[2]

Additionally, Secretary Burwell has set her sights on expanding this shift from FFS to quality-based reimbursement beyond Medicare. Burwell announced the creation of a Health Care Payment Learning and Action Network to work with private payers, employers, consumers, providers, states and state Medicaid programs to expand alternative payment models into their programs. The Network is scheduled to hold it first meeting in March 2015, with HHS promising more details in the near future.

HHS is optimistic in achieving its goals, noting in its press release that it has “already seen promising results on cost savings with alternative payment models” through a combined total program savings of $417 million to Medicare due to existing ACO programs. Moreover, it “expects these models to continue the unprecedented slowdown in health care spending.”

Yet there is some uncertainty as to how well these payment approaches will work. A 2014 Rand Corporation study funded by HHS concluded, “We still know very little about how best to design and implement [value-based payment] programs to achieve stated goals and what constitutes a successful program.”[3] The report reviewed pay-for-performance models implemented over the past decade, and tempered the improvements cited by HHS.
with a dose of caution—“improvements were typically modest” and often hard to evaluate. If the HHS reaches its stated goals, such improvements may be easier to evaluate come 2018.


[2] More information about the Hospital Value Based Purchasing program can be found here; and information about the Hospital Readmissions Reduction program can be found here.

[3] The 2014 Rand Corporation study funded by HHS can be found here; (See pages 26, 35).

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