HHS Announces Timeline for Accelerated Transition to Value-Based Payments in Medicare Program

SUMMARY

On January 26, 2015, the U.S. Department of Health and Human Services (“HHS”) announced the launch of the Better Care. Smarter Spending. Healthier People: Why it Matters initiative. According to HHS, this is the first time the agency has identified specific goals and a timeline for transitioning the Medicare program away from the historic fee-for-service model and toward a system that ties Medicare reimbursements to alternative payment models and value-based payments.

In its announcement, HHS stated two distinct goals. First, HHS plans to tie 30 percent of fee-for-service Medicare payments to quality or value through alternative payment models by the end of 2016 and 50 percent of Medicare payments by the end of 2018. HHS suggested that this would be accomplished through payment models such as accountable care organizations (ACOs) and bundled payment arrangements.

Second, HHS intends to tie 85 percent of all traditional, fee-for-service, Medicare payments to quality or value by 2016 and 90 percent of Medicare payments to these goals by 2018. HHS stated that it would accomplish this goal through programs such as Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

In support of this initiative, and a movement away from volume based reimbursements, HHS stated that the Medicare program has realized a total savings of $417 million through existing ACO programs. HHS also noted that approximately 20 percent of Medicare payments today are being made through alternative payment models – up from almost no such payments in 2011.

HHS has not announced or published further details of how it will achieve these two goals or a timeframe within which HHS will release this detailed information. HHS’ fact sheet for this initiative focused on three areas: (1) payment incentives to improve the way providers are paid; (2) improving and innovating care delivery; and (3) information sharing to increase transparency and yet maintain patient privacy.

As part of its announcement, HHS stated that a Health Care Payment Learning and Action Network (HCPLAN) has been created to expand alternative payment models beyond the Medicare program. HCPLAN will hold its first meeting in March 2015. According to HHS, HCPLAN will work with private
Providers and payors remain intently focused on developing payment models that reward value and achieve quality outcomes for individuals. Employers are increasingly demanding these initiatives for their employees and dependents. Economic pressures will likely continue to result in the degradation of fee-for-service reimbursement models. Providers who embrace quality outcomes and who have the tools to measure these results may be the beneficiaries of competitive contracts with payors and be embraced by employers.

Saul Ewing has followed and written articles about the Medicare Shared Savings Program and ACOs. Those articles are available at http://tinyurl.com/o9az8zv.

Saul Ewing attorney are knowledgeable about Medicare, Medicaid and commercial payor payment initiatives. They have counseled clients on the creation of and other issues associated with ACOs (both Medicare and commercial) and the creation of alternative payment methodologies. For more information on these matters, please contact the authors or the attorney at the firm with whom you are regularly in contact.