

HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements From Volume to Value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services (HHS) Secretary Sylvia M. Burwell recently announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. HHS will intensify its work with states and private payers to support adoption of alternative payments models through their own aligned work, sometimes even exceeding

the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

The Affordable Care Act created a number of new payment models that move the needle even further toward rewarding quality. These models include ACOs, primary care medical homes, and new models of bundling payments for episodes of care. In these alternative payment models, health care providers are accountable for the quality and cost of the care

they deliver to patients. Providers have a financial incentive to coordinate care for their patients – who are therefore less likely to have duplicative or unnecessary x-rays, screenings and tests. An ACO, for example, is a group of doctors, hospitals and health care providers that work together to provide higher-quality coordinated care to their patients, while helping to slow health care cost growth. In addition, through the widespread use of health information technology, the health care data needed to track these efforts is now available.

Many health care providers today receive a payment for each individual service, such as a physician visit, surgery, or blood test, and it does not matter whether these services help – or harm – the patient. In other words, providers are paid based on the volume of care, rather than the value of care provided to patients. Today's announcement would continue the shift toward paying providers for what works – whether it is something as complex as preventing or treating disease, or something as straightforward as making sure a patient has time to ask questions.