PUBLICATION

HHS Identifies Specific Goals to Move Toward Paying for Quality of Care [Ober|Kaler]

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On January 26, 2015, the U.S. Department of Health and Human Services (HHS) announced a new initiative to shift Medicare reimbursements from volume to value using new payment methodologies for physicians and hospitals. Such a move would support the government's ongoing efforts to link Medicare reimbursement to quality of care.

HHS identified two primary goals to push towards paying for quality of care: (1) tying 30% of traditional fee-for-service Medicare payments to quality or value through alternative payment models by the end of 2016, increasing to 50% by the end of 2018; and (2) tying 85% of all traditional Medicare payments to quality or value by 2016, increasing to 90% by 2018, through programs like the Hospital Value Based Purchasing Program and the Hospital Readmission Reduction Program.

For these reforms to gain widespread participation, private payors will likely need to follow suit. To that end, HHS will bring together industry players through the Health Care Payment Learning and Action Network. Through that group, HHS will work with private payors, employers, consumers, providers, and states to implement and expand the alternative payment models into the non-Medicare private sector.

HHS's announcement has sparked considerable industry commentary, including concerns about what the financial impact on certain providers and types of providers might be under the changes being proposed.

Ober|Kaler's Comments

The HHS proposals are thought provoking and raise a number of questions. For example, there are questions about whether HHS currently has the statutory authority to implement the changes being proposed. That authority seems questionable, and congressional agreement with the proposals would seem to be necessary. Even if HHS currently possesses such authority, however, notice and comment rulemaking would seem to be necessary. Further, it would also appear that to gain further “buy-in” to the alternative payment methodologies and to reach the higher percentages, HHS may need to incentivize providers to participate in existing voluntary programs, particularly those with a heightened focus on quality initiatives. All of this will mean that much more debate concerning the HHS proposal is in the offing.