Insight

HHS Takes Wrong Steps in the Right Direction

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Yesterday, Health and Human Services (HHS) Secretary Sylvia Burwell announced specific targets for moving Medicare towards a payment model based on "value" rather than volume of service. This is the first time in Medicare's fifty year history that explicitly stated goals for alternative payment models and value-based payments have been set by HHS.

While setting goals is an important first step to bringing about much-needed change, it is equally important that those goals be achievable. HHS has proposed 30 percent of traditional fee-for-service payments be tied to value or quality by the end of 2016, and 50 percent by the end of 2018; this would be a 50 percent increase in the next two years and then a 67 percent increase the following two years. Additionally, HHS has proposed 85 percent of *all* Medicare payments be tied to value or quality by 2016, and 90 percent by 2018. Ambitious goals are great, but unrealistic goals simply set us up for failure.

HHS has set out broad standards for meeting these goals by referring to "value" and "quality" without ever defining these words. The alternative payment methods HHS references have had varying degrees of success in reining in costs and improving quality, though none have proven to be especially successful.

The Medicare Shared Savings Program, for example, saw small benefits: 114 Accountable Care Organizations (ACOs) in the first year of the program, only 29 succeeded in generating a combined $128 million in savings; only four ACOs opted to share in upside-downside risk, and half of those shared in losses.[1] Most concerning of all, however, is that the ACOs pressured HHS to waive the quality improvement benchmark standards, and to allow ACOs to continue to participate only in upside risk sharing. This means that ACOs will continue to share in any savings they generate with no risk of shared losses, yet they are under no obligation to produce any quality improvements.

Likewise, a recent RAND study has indicated that value based purchasing (VBP) programs create "modest" improvements in quality of care, but acknowledges that studies with better methodology tend to demonstrate less correlation between VBP programs and improved quality outcomes.[2] It is possible that VBP best lends itself to care of certain Diagnostic Related Groups over others.

Studies by the National Institutes of Health, among others, have also demonstrated that while hospital readmission reduction programs do little to reduce the rate of readmission, they are correlated with slight reductions in initial hospitalizations.[3]

Overall, ACOs have been a dismal failure, VBP has had mixed results, and hospital readmission reduction programs appear to have no impact whatsoever. Yet HHS is calling for the expansion of these programs to an ambitious 90 percent of the health care sector over the next four years.

Along with these new payment goals came the announcement of the creation of the Health Care Payment Learning and Action Network. This network, it is hoped, will allow HHS to work with private payers,

employers, consumers, providers, states, Medicaid operators, and others to expand alternative payment models into their own programs. This sounds good on the surface, as one of the critical factors to making performance-based payment models successful is ensuring that the goals and metrics being measured by various payers are well-aligned so as not to create conflicting objectives for the care providers. However, it is questionable how useful this Network will really be, when it is well-known that Medicare is the largest health care payer in the country; insurers are effectively obliged to accept standards set by Medicare.

Also of serious concern is how the administration seems to be undermining ongoing Congressional efforts regarding Sustainable Growth Rate (SGR) reform. In a rare showing of bipartisanship on substantive issues in the last Congress, Republicans and Democrats from both the House and Senate agreed to a plan to replace the SGR with a new payment structure which may actually be sustainable. Just last week, the House Energy and Commerce Committee held two days of hearings to discuss options for paying for replacement of the SGR, the one piece of the puzzle yet to be resolved. By announcing such changes while Congress is in the middle of negotiations to finalize their plans, the Secretary may be undermining those efforts.

[1] http://americanactionforum.org/insights/accountable-care-organizations-what-the-demonstration-projects-tell-us