Continuing the shift from volume to results in American healthcare
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Almost a year ago, the Administration announced a vision for the future of the Medicare program, including clear goals and a timeline for shifting Medicare payments from volume to value. CMS is continually working to turn this vision into reality through annual rulemaking and the CMS Innovation Center, building on bipartisan ideas, initiatives and legislation from both Congress and the states.

For example, we recently published the final 2016 Medicare provider payment rules. Woven into those very detailed payment rules and regulations are new examples of the administration's commitment to quality, value, and patient-centered care. These include:

- **Creating the Home Health Value-Based Purchasing model.** This model will link home health payments to quality performance with the goal of improving health outcomes. All Medicare-certified home health agencies that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee will participate in this model starting January 1, 2016.
- **Replacing the Sustainable Growth Rate (SGR) update formula for physician services with one that supports patient- and family-centered care.** CMS is taking the first steps to implement the Merit-Based Incentive Payment System (MIPS) and incentives for participation in Alternative Payment Models (APMs). These new approaches, part of the bipartisan Medicare Access and CHIP Reauthorization Act, will give physicians and other practitioners the opportunity to be rewarded for providing high quality care at lower costs, will reduce administrative burden, and will enable doctors to spend more time with their patients.
- **Paying for advance care planning.** A wide range of stakeholders and bipartisan members of Congress supported our proposal to make separate payments to doctors and other practitioners who provide elective advance care planning services to Medicare beneficiaries in a variety of settings. We believe this policy supports patient- and family-centered care for seniors and other Medicare beneficiaries.

In addition to the efforts mentioned above, the CMS Innovation Center is testing a variety of models that build on the Administration's measurable goals and 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. The CMS Innovation Center opened its doors five years ago to test new payment and service delivery models that either improve quality while keeping costs the same, maintain quality and lower costs, or – best case scenario – improve quality and lower costs.

We have seen some positive results from models that the Innovation Center is testing. Savings in the Pioneer ACO Model were so significant – and coupled with positive results on improved quality of care and better patient experience – that the independent CMS Office of the Actuary certified that expansion of the model as it was tested in the first two years would reduce net program spending under Medicare. We have also incorporated elements of the Pioneer ACO Model into the Medicare Shared Savings Program, which reaches more beneficiaries in more areas of the country. We are actively evaluating other models to see if they meet this bar and have applied lessons and feedback from the Innovation Center models throughout the Medicare program.

One of the most promising trends we're seeing is the significant improvement in patient safety and decreased adverse incidents in the hospital setting. Thanks to several CMS programs that are improving patient safety in hospitals, such as the Partnership for Patients, from 2010 to 2013, there has been 1.3 million fewer hospital acquired conditions and 50,000 patient deaths avoided, leading to an estimated $12 billion savings in health care costs. This translates into a 17 percent reduction in patient harm nationally over the three-year period. This is a promising start, but we are committed to doing more.

Other CMS Innovation Center models that are moving the needle from volume to value include:

- Our recently finalized **Comprehensive Care for Joint Replacement model**, a bundled payment model for hip and knee replacements for Medicare beneficiaries set to begin in April 2016. The model's goal is to give hospitals a financial incentive to work with physicians, home health agencies, skilled nursing facilities, and other providers to ensure beneficiaries get the coordinated care they need.
- Our **Bundled Payment for Care Improvement initiative** had, as of October 1, 2015, over 1,600 hospitals, physician groups, post-acute care facilities, and other providers taking on the challenge of managing patients care for an entire episode of care, improving quality, and spending dollars more wisely.
- Our primary care models, including the **Comprehensive Primary Care Initiative** and **Independence at Home Demonstration**, are demonstrating the ability of redesigned primary care to improve quality and patient experience while lowering costs. The Independence at Home demonstration saved over $3,000 per beneficiary in its first year through coordinated care for beneficiaries with multiple chronic conditions.
- Our **State Innovation Models initiative** has 38 states and territories engaging at the state and the local level to achieve better care, smarter spending, and healthier people. The **Maryland All-Payer Model** resulted in over $100 million in Medicare savings in the first year and improved quality. These are just a few examples of the efforts over the past year that have us on track to hit our two Medicare payment goals – tying 30 percent of traditional Medicare payments to alternative payment models and tying 85 percent of all traditional Medicare payments to quality or value – by the end of 2016. We are also working with private payers, state Medicaid agencies and associations, provider organizations, and consumer and purchaser groups through the Health Care Payment Learning and Action Network around setting similar goals. Many of these organizations have already set similar, aligned goals, and we are working to implement these new models of care across the nation through public-private partnerships. To date, over 4,000 individuals and 610 organizations have committed to participate in the Learning and Action Network, and 50 partners have set organization-specific goals to encourage adoption of value based payment. These efforts have contributed to putting Medicare and Medicaid on stronger financial footing with improved quality. Per enrollee Medicare spending growth has been low, averaging 1.3 percent over the last five years. The Medicare trust fund will remain solvent 13 years longer than the Medicare Trustees projected in 2009, before the passage of the Affordable Care Act. We are pleased with the progress towards transforming our healthcare system into one that is better, smarter, and results in healthier people. But, there is more work to be done. The last five years have seen the most positive delivery system improvements in our nation's history, and we are committed to accelerating that progress. We want to test new models, learn what works, and scale successes rapidly. And we cannot and do not want to do this alone. Through working with both the private and public sectors, we know that we can accomplish the common goals – delivering better and improved care while spending taxpayer dollars wisely – that will result in healthier Americans. Let's move forward together.