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Center for Medicare and Medicaid Innovation

Time to Get Back on Track

By Madeline Twomey May 4, 2018

One key avenue to reduce health care costs has remained stagnant under the Trump administration. After several months without a leader, the Center for Medicare and Medicaid Innovation (CMMI) is set to bring on Adam Boehler as its director. The CMMI is responsible for testing payment and delivery system reforms to reduce health care costs while improving or maintaining quality of care.[1] Many have been uncertain about the future of the CMMI; while the health care landscape has undoubtedly been turbulent in the Trump era, most of the public attention has centered on the repeal attempts and ongoing sabotage of the Affordable Care Act (ACA). Nevertheless, the CMMI has the potential to affect millions of patients and providers as well as the health care system at large.

Thus far, changes to the CMMI under the Trump administration have been fairly limited, but the actions of top officials have indicated a troublesome shift in the CMMI's priorities. Instead of focusing on improving care and lowering costs for patients, Centers for Medicare and Medicaid Services (CMS) leaders are prioritizing providers' flexibility and choice by allowing promising payment models to become voluntary. Furthermore, a recent proposal to test direct private contracting potentially lays the groundwork for conservative efforts to overhaul Medicare. As Boehler settles in to his role, he should work quickly to reset the CMMI's goals and continue testing and building on alternative payment models.

Background

The CMMI—which was established with the passage of the ACA—provides a critical framework for addressing rising health care costs. With approximately $1 billion per year in funding, it has significant flexibility to design and test different payment and delivery models that help reduce health care costs while maintaining or improving quality of care. It also assesses models that help improve quality of care while simultaneously keeping costs the same.[2] The ultimate goal is for Medicare and Medicaid to move away

from traditional fee-for-service payments, which pay doctors, hospitals, and other health care providers separately for each item or service furnished to a patient.[3] Fee-for-service payments can incentivize the overutilization of health care services in ways that have little positive effect on health outcomes.[4] If one of the CMMI's demonstration models achieves significant savings and maintains or improves quality, the CMMI has the authority to expand the model to the full Medicare program.[5]

Since its inception, the CMMI has tested and implemented 37 models, including bundled payments, accountable care organizations (ACOs), and primary care medical homes.[6] These models incentivize preventive care and care coordination or otherwise tie payment to outcomes, instead of solely basing payments on the volume of services given to patients. They also often target patients with chronic illnesses or those with multiple conditions.[7] As of 2016, Medicare made over 30 percent of payments through alternative payment models.[8]

Alternatives to fee-for-service payments in health care

Per a 2012 Center for American Progress report, definitions of alternatives to fee-for-service payments include:[9]

Bundled payments: Fixed amounts paid to health care providers for a bundle of services or all the care a patient is expected to need during a period of time

Accountable care organizations: Groups of health care providers who agree to share responsibility for coordinating lower-cost, higher-quality care for a group of patients

Patient-centered medical homes: Redesigned primary care practices that focus more on preventive care, patient education, and care coordination between different health care providers

Trump administration rollback of previous CMMI initiatives

The Obama administration was ambitious in its efforts to study the effects of different payment and delivery reforms. It even planned to test different ways to reduce drug costs under Medicare Part B; however, this program was not ultimately implemented.[10] Under former Department of Health and Human Services (HHS) Secretary Sylvia Burwell, for the first time, the federal government set an official target for the percent of Medicare spending paid through alternative payment models, aiming for alternative models to represent 50 percent of payments by 2018.[11] Unfortunately, the Trump administration has pulled away from this goal, and leaders have said that there is no longer an official target.[12]

Of the types of reforms tested by the CMMI, bundled payments carry significant potential for certain types of care. Generally, bundled payments have proven to be able to generate savings and be implemented across providers and geographic locations without imposing significant upfront costs.[13] Building on the success of the Acute Care Episode (ACE) demonstration, which provided fixed payments for cardiac and orthopedic procedures in hospital sites across four states,[14] the Obama administration launched large-scale, mandatory bundled payment demonstration models.[15] These included the Comprehensive Care for Joint Replacement (CJR)—a bundled payment model for hip and knee replacements in 67 geographic areas—and the Cardiac Rehabilitation Incentive Payment Model,[16] which aimed to incentivize providers to utilize cardiac rehabilitation in 90 geographic areas.[17] Unfortunately, the Trump administration already canceled the cardiac model and scaled back CJR, making the program partially voluntary. Officials have argued that these changes will offer "greater flexibility and choice" for providers.[18]

Indeed, conservatives have long argued that mandatory payment models can impose burdensome requirements on providers. However, shifting to voluntary programs undermines the design of bundled payment models; the Obama administration recognized that the mandatory nature of these models was important because voluntary models are subject to "selection bias."[19] In other words, institutions that are better equipped to implement changes are more likely to participate in voluntary models, leaving other providers behind. At the same time, the worst-performing providers most in need of reform are more likely to opt out of the voluntary approach. Therefore, the results of a given test may not accurately reflect the health care landscape, making it harder to generate reliable data and expand the model nationwide.

Unfortunately, under President Donald Trump, the CMMI has been rolling back mandatory bundled payment models while continuing to move forward with voluntary models. These voluntary models allow providers to pick and choose the services to be bundled and carry less potential for broad reform. A shift to voluntary payment models also reduces the potential for savings. The CJR model was initially mandatory for hospitals in 67 areas throughout the country, but HHS has since made the program voluntary for 33 of these locations.[20] The CMS estimated that this rollback of CJR lowers the projected savings of the program by $108 million.[21] The new estimated savings for the CJR model are $189 million—versus the original projected savings of $294 million.[22]

New CMMI proposals under the Trump administration

In September 2017, the CMMI released a request for information (RFI) letter titled "Innovation Center New Direction," requesting policy feedback under the guiding principles of "choice and competition in the market" and "provider choice and incentives."[23] CMS Administrator Seema Verma published an accompanying op-ed in *The Wall Street Journal* titled "Medicare and Medicaid Need Innovation," in which she echoed this desire to focus on market competition and reducing provider requirements.[24]

The RFI and op-ed suggest that, instead of focusing on improving care, the CMMI is looking at models that have the potential to simply shift health care costs to consumers. For example, after asserting that "consumer-directed care models could empower Medicare, Medicaid, and CHIP beneficiaries to make choices from among competitors in a market-driven healthcare system," the RFI lays out plans to test private contracting in Medicare, which could result in providers being allowed to charge patients higher rates.[25]

Moreover, in her op-ed, Verma specifically references looking into paying bonuses to doctors who treat a high number of seniors on private Medicare plans.[26] Incentivizing providers to treat patients on private plans does not necessarily serve patients but merely serves to support an ideological message that tips the scale in favor of the private market. Even in the case that this model could increase accessibility for the Medicare population, focusing on provider incentives does nothing to address rising costs for patients. Even worse, according to news reports, "administration officials confirmed that the language was meant to signal an interest in premium support," which is a longstanding conservative policy idea that would shift Medicare from a defined benefit system to one in which seniors receive vouchers to purchase insurance.[27]

These troubling proposals did not go unnoticed. In response to the RFI, 15 U.S. senators—14 Democrats and one Independent—released a letter expressing concern about the CMMI's use of ambiguous language.[28] While the senators acknowledged that the RFI does not explicitly mention vouchers or premium support, they argued that the concepts mentioned in the RFI seek to "radically restructure" Medicare and potentially lay the groundwork for these types of proposals. [29] The letter reads, "the authority granted to the Innovation Center does not allow the agency to systematically unravel the Medicare guarantee or weaken critical beneficiary safeguards established by Congress."[30] This is correct. Any type of premium support proposal that would significantly shift costs to seniors over time is the wrong approach for the CMMI.

On April 23, the CMMI announced that it is requesting a follow-up RFI centered around direct private contracting.[31] This type of proposal would involve Medicare contracting with primary care providers' practices through a monthly payment meant to cover each enrolled beneficiary's medical care. This is similar to proposals previously endorsed by former HHS Secretary Tom Price, who, as a former orthopedic surgeon, was a strong supporter of initiatives that tended to favor providers' financial interests—such as private contracting and balance billing proposals that would allow doctors to charge patients more than Medicare prices.[32] Of course, Price has since resigned from his role at HHS, but his legacy continues to influence the CMMI's priorities. Although the RFI does not directly signal an intent to allow physicians to charge Medicare patients higher prices, Price's history of supporting such proposals indicates that the RFI's direct contracting proposal may be a step in this direction.

Conclusion

Given rising health care costs, the need for the CMMI remains as urgent as ever. So far, Trump officials have appeared to pay relatively little attention to the CMMI—and when they have, they have primarily viewed it as a vehicle for ideological reforms to Medicare that could leave patients worse off. Adam Boehler's appointment offers the CMMI an opportunity to get back on track. Instead of rolling back the progress made under the Obama administration and abusing its authority to consider proposals like balance billing and premium support, Boehler should continue the CMMI's legacy of bipartisan consensus and focus on demonstration models that seek to reduce costs and improve care for patients. In order to achieve this goal, Boehler should work quickly to convene a bipartisan group of experts to recommend priorities and establish meaningful goals.

Previous CMMI Director Patrick Conway argued that the primary objective of the CMMI was "to ensure quality health care for generations to come—not just for Medicare and Medicaid beneficiaries, but for all people who depend on our Nation's health care system."[33] As the CMMI moves forward, its proposals should be judged by whether they carry the potential to actually reduce health care costs, or whether they merely shift costs to patients.

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Endnotes

1 John Gregory, "Adam Boehler officially named new CMMI director," *HealthExec,* April 6, 2018, available at http://www.healthexec.com/topics/leadership/adam-boehler-officially-named-new-cmmi-director.

2 Henry J. Kaiser Family Foundation, " 'What is CMMI?' and 11 other FAQs about the CMS Innovation Center," February 27, 2018, available at https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/.

3 Maura Calsyn and Emily Oshima Lee, "Alternatives to Fee-for-Service Payments in Health Care" (Washington: Center for American Progress, 2012), available at https://www.americanprogress.org/issues/healthcare/reports/2012/09/18/38320/alternatives-to-fee-for-service-payments-in-health-care/.

4 Ibid.

5 Kaiser Family Foundation, " 'What is CMMI?' and 11 other FAQs about the CMS Innovation Center."

6 U.S. Government Accountability Office, "CMS Innovation Center: Model Implementation and Center Performance" (2018), available at https://www.gao.gov/assets/700/690875.pdf.

7 Calsyn and Oshima Lee, "Alternatives to Fee-for-Service Payments in Health Care."

8 Topher Spiro, "Center for Medicare and Medicaid Innovation: Scoring Assumptions and Real-World Implications," Testimony before the U.S. House Committee on the Budget, September 7, 2016, available at https://budget.house.gov/uploadedfiles/spiro_testimony.pdf.

9 Calsyn and Oshima Lee, "Alternatives to Fee-for-Service Payments in Health Care."

10 This model reduced financial incentives for doctors to prescribe higher cost medications.

11 Sylvia M. Burwell, "Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care," *The New England Journal of Medicine* 372 (10) (2015): 897–899, available at https://www.canceradvocacy.org/wp-content/uploads/2015/03/Burwell-NEJM-Value-Based-Payment-Goals.pdf.

12 Paige Winfield Cunningham, "The Health 202: Trump administration pulls back from key Medicare goals," *The Washington Post,* February 20, 2018, available at https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/02/20/the-health-202-trump-administration-pulls-back-from-key-medicare-goals/5a8737f430fb047655a067d4/?.

13 Center for American Progress, "Health Policy Leaders and Doctors Call on HHS to Test More Mandatory Bundled Payment Models," Press release, June 24, 2016, available at https://www.americanprogress.org/press/release/2016/06/24/140370/release-health-policy-leaders-and-doctors-call-on-hhs-to-test-more-mandatory-bundled-payment-models/; Maura Calsyn and Ezekiel Emanuel, "Controlling Costs by Expanding the Medicare Acute Care Episode Demonstration," *Journal of the American Medical Association* 174 (9) (2014): 1438–1439, available at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1885468?guestAccessKey=e0c47485-5500-4964-8f2e-2278693f3f93.

14 The Acute Care Episode demonstration was a three-year test that resulted in approximately $4 million in savings without compromising quality of care.

15 Centers for Medicare and Medicaid Services, "Medicare Acute Care Episode (ACA) Demonstration," available at https://innovation.cms.gov/initiatives/ACE (last accessed May 2018).

16 This model was scheduled to begin in January 2018.

17 Centers for Medicare and Medicaid Services, "Cardiac Rehabilitation Incentive Payment Model" (2016), available at https://innovation.cms.gov/Files/fact-sheet/cr-provider-tech-fs.pdf.

18 Centers for Medicare and Medicaid Services, "CMS finalizes changes to the Comprehensive Care for Joint Replacement Model, cancels Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model," Press release, November 30, 2017, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-30.html.

19 Spiro, "Center for Medicare and Medicaid Innovation: Scoring Assumptions and Real-World Implications."

20 Centers for Medicare and Medicaid Services, "CMS finalizes changes to the Comprehensive Care for Joint Replacement Model, cancels Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model."

21 Kaiser Family Foundation, " 'What is CMMI?' and 11 other FAQs about the CMS Innovation Center."

22 U.S. Department of Health and Human Services, "Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model: Extreme and Uncontrollable Circumstances Policy for the Comprehensive Care for Joint Replacement Payment Model," *Federal Register* 82 (230) (2017), available at https://www.gpo.gov/fdsys/pkg/FR-2017-12-01/pdf/2017-25979.pdf.

23 Centers for Medicare and Medicaid Services, "Innovation Center New Direction" (2017), available at https://innovation.cms.gov/Files/x/newdirection-rfi.pdf.

24 Seema Verma, "Medicare and Medicaid Need Innovation," *The Wall Street Journal*, September 19, 2017, available at https://www.wsj.com/articles/medicare-and-medicaid-need-innovation-1505862017.

25 Centers for Medicare and Medicaid Services, "Innovation Center New Direction."

26 David Pittman, "Medicare innovation lab faces brain drain, scant buy-in," *Politico*, March 22, 2018, available at https://www.politico.com/story/2018/03/22/medicare-innovation-lab-faces-brain-drain-scant-buy-in-370824.

27 Erin Mershon, "HHS hints at major changes to Medicare that could mean higher costs for patients," Stat News, September 21, 2017, available at https://www.statnews.com/2017/09/21/hhs-changes-medicare-costs-patients/.

28 Letter from Sen. Bob Casey (D-PA) and others to Seema Verma, February 22, 2018, available at https://www.aging.senate.gov/imo/media/doc/CMMI%20Letter.pdf.

29 Ibid.

30 Ibid.

31 Centers for Medicare and Medicaid Services, "Feedback on New Direction Request for Information (RFI) Released, CMS Innovation Center's Market-Driven Reforms to Focus on Patient-Centered Care," Press release, April 23, 2018, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-04-23.html.

32 Virgil Dickson, "Price backs balance billing for Medicare patients," *Modern Healthcare*, March 9, 2017, available at http://www.modernhealthcare.com/article/20170309/NEWS/170309880.

33 Patrick Conway, "U.S. Efforts to Reduce Healthcare-Associated Infections," Testimony before the U.S. Senate Committee on Health, Education, Labor, and Pensions, September 24, 2013, available at https://www.help.senate.gov/imo/media/doc/Conway.pdf.