

# Accelerating Payment Reform in Medicare

*How CMS Can Implement More Successful  
Alternative Payment Models More Quickly*

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# ACCELERATING PAYMENT REFORM IN MEDICARE EXECUTIVE SUMMARY

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There is broad consensus that the fee-for-service payment systems currently used in Medicare create significant barriers to delivering higher-quality care to Medicare beneficiaries at a more affordable cost. Properly-designed Alternative Payment Models (APMs) are needed to solve the problems with both current fee-for-service payment systems and pay-for-performance programs.

## Problems With CMS's Current Approach to Creating Alternative Payment Models

In 2010, Congress created the Center for Medicare and Medicaid Innovation (CMMI) and provided it with \$10 billion in funding over a ten year period in order to create Alternative Payment Models. However, after more than seven years and more than \$5 billion in spending, only five payment models created by CMMI meet the APM requirements established by Congress, and only one of the models tested by CMMI has been expanded nationally. The slow progress in implementing successful Alternative Payment Models means that each year, millions of Medicare beneficiaries are being denied the opportunity to receive higher-quality care and the Medicare program is spending billions of dollars more than is necessary.

The lack of progress is due to several problems with the approach CMMI has used for developing and testing Alternative Payment Models:

- Most of the APMs being tested don't solve the problems with fee-for-service payment.
- Too few physician-focused payment models are being tested.
- The CMMI testing process is slow, burdensome, expensive, and discourages significant innovation.

## How CMS Can Implement More Successful Alternative Payment Models More Quickly

CMS and CMMI could dramatically accelerate the implementation of APMs through the following steps:

### 1. Embrace a Bottom-Up Approach to Payment Innovation at CMS

As part of MACRA, Congress created a bottom-up approach that specifically welcomes APMs designed by physicians and other practitioners and that encourages development of APMs and delivery models that are feasible for small physician practices and small hospitals to implement. **CMS should embrace the process that Congress has created and commit to quickly implement all of the physician-focused**

### Alternative Payment Models that are recommended by the Physician-Focused Payment Model Technical Advisory Committee.

In addition, there are a number of communities across the country where physicians, hospitals, and other providers are working with patients, employers, health plans, and other purchasers to develop and implement alternative payment models that support high quality, more affordable care. **If a group of providers and payers in a state or region have developed or implemented an innovative APM, CMS should agree to implement a similar approach to paying for the care of Medicare beneficiaries in that community so that the providers can have full multi-payer support.**

### 2. Create the Capacity at CMS and its MACs to Implement Bundled Payments and Other Alternative Payment Models

There is no single alternative payment model that will work for all types of patients and all types of healthcare providers. **CMS and its Medicare Administrative Contractors (MACs) should quickly make the changes needed in Medicare claims payment and other administrative systems to support implementation of seven types of alternative payment model structures:**

1. Payments for High-Value Services
2. Condition-Based Payments for Physician Services
3. Multi-Physician Bundled Payments
4. Physician-Facility Procedure Bundles
5. Warranted Payments for Physician Services
6. Episode Payments for Procedures
7. Condition-Based Payments

In addition, **CMS should revise the definition of "financial risk" in the MACRA regulations to enable design of Advanced APMs that small physician practices can feasibly participate in. CMS should also designate any APM that is undergoing testing by the Innovation Center as an "Advanced" APM.**

### 3. Use Limited Scale Testing to Accelerate Innovation

Fully specifying the parameters of an innovative Alternative Payment Model often requires information that can only be obtained from providers who are delivering services in a different way, but providers cannot deliver services in that way without having an alternative payment model to support them. Currently, CMMI will only test a payment model if it projects that

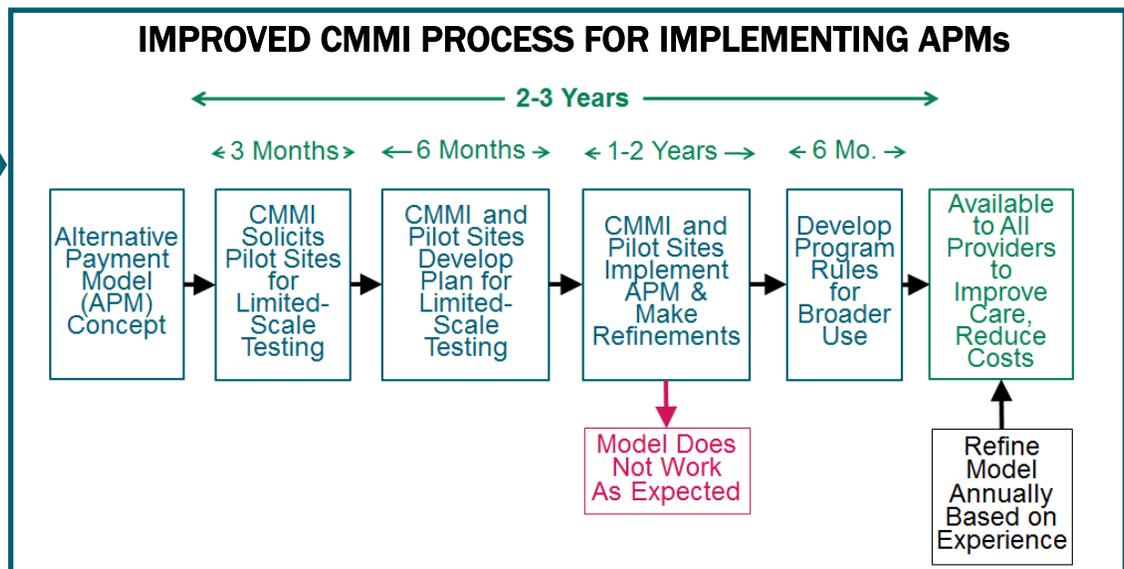
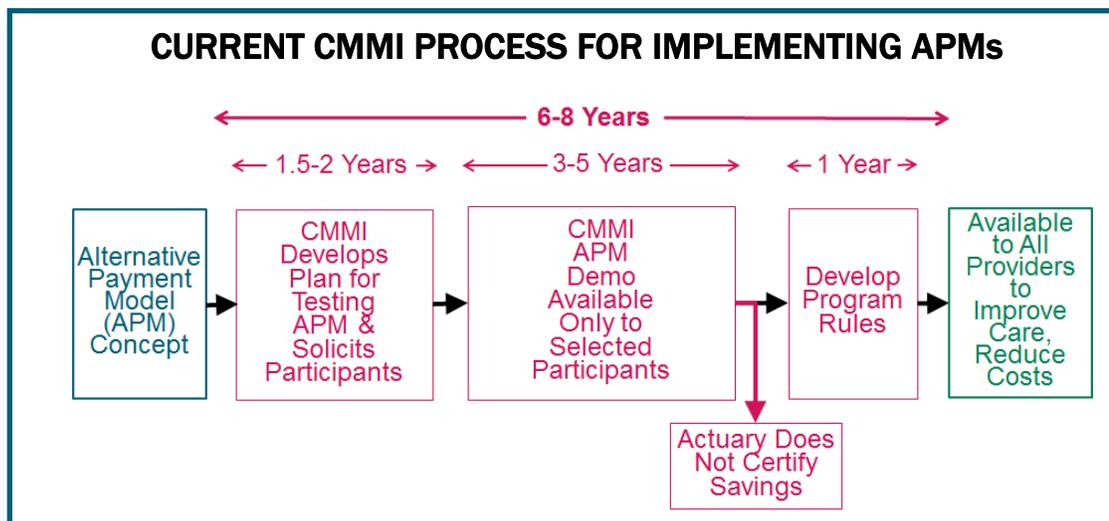
the model will reduce Medicare spending. However, since it is impossible to confidently make such a projection without specifying the parameters of the model, CMMI's current approach means that most innovative models will never be tested.

To address this problem, **CMMI should create a process for "limited scale testing" of innovative alternative payment models.** The following five-step process could be used for this:

1. Recruit volunteers to serve as pilot sites for limited-scale testing of the APM.
2. Implement the APM at the pilot sites.
3. Adjust the parameters of the APM using clinical and cost data collected by the pilot sites.
4. Implement the APM on a broader scale if the limited-scale testing is successful.
5. Help pilot sites transition if the APM is not continued.

#### 4. Create a Faster, More Efficient Approach for Implementing APMs

If CMMI continues to use its current process for testing and implementing alternative payment models in the future, it would take a decade before the majority of physicians in the country would have the ability to participate in an APM designed for the types of patients they care for. **CMMI should completely redesign the processes it uses to test and implement alternative payment models in order to achieve the goals that are implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from well-designed alternative payment models in 2019, at least 50% of their revenues from APMs in 2021, and at least 75% of their revenues from APMs in 2023.** To ensure that the MACRA goals are achieved, CMS should establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible.



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# I. THE NEED FOR MORE ALTERNATIVE PAYMENT MODELS IN MEDICARE

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There is broad consensus that the fee-for-service payment systems currently used in Medicare create significant barriers to delivering higher-quality care to Medicare beneficiaries at a more affordable cost. Medicare's current payment systems do not pay at all for many types of high-value services that would benefit patients and help reduce avoidable spending<sup>1</sup>, and its current systems financially penalize physicians, hospitals, and other healthcare providers when they help patients stay healthy and when they eliminate unnecessary and duplicative services.

There is also growing concern about the administrative burdens associated with requiring providers to report large numbers of quality measures and the unfair penalties that can be imposed on providers who care for complex and vulnerable patients.<sup>2</sup>

Properly-designed Alternative Payment Models (APMs) can solve the problems with current fee-for-service payment systems and pay-for-performance programs. By paying for high-value services, eliminating financial penalties when better outcomes are achieved, and focusing accountability on aspects of quality and spending that providers are able to control, APMs can support the delivery of higher-quality care for patients and reduce spending for Medicare in ways that are financially feasible for physicians, hospitals, and other healthcare providers.<sup>3</sup>

In the Patient Protection and Affordable Care Act of 2010 (ACA), Congress provided significant new resources to support the creation of Alternative Payment Models in Medicare. Five years later, in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress added incentives for physicians to

participate in APMs and it specifically encouraged the creation of "physician-focused payment models." Unfortunately, more than seven years after passage of the ACA and more than two years after passage of MACRA, little progress has been made in creating Medicare APMs for most physicians, hospitals, and other healthcare providers, and the APMs that have been created by CMS have not been successful in achieving significant savings. For example:

- CMS has only created seven Alternative Payment Models that enable physicians to qualify for the higher payment amounts authorized by Congress and to be exempt from MIPS.<sup>4</sup> CMS has projected that in 2018, fewer than 5% of clinicians will participate in one of these models.<sup>5</sup>
- Instead of generating savings for Medicare, the largest Medicare APM – the Medicare Shared Savings Program – has *increased* Medicare spending for four straight years.<sup>6</sup>

Clearly, more and better Alternative Payment Models are needed in Medicare. Moreover, because Medicare is the largest individual payer in the country, and since many commercial health plans utilize the payment systems that Medicare implements, slow progress in implementing APMs in Medicare also impedes progress in delivering higher-quality, more affordable healthcare services to all Americans.

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# II. CMS AUTHORITY AND FUNDING TO DEVELOP AND IMPLEMENT APMs

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The Medicare program has had the ability to develop and test alternative ways to pay healthcare providers for 50 years. Section 402 of the Social Security Amendments of 1967<sup>7</sup> authorized the Secretary of Health and Human Services (HHS) to “develop and engage in experiments and demonstration projects...to determine whether...changes in methods of payment or reimbursement...would have the effect of increasing the efficiency and economy of health services...without adversely affecting the quality of such services.”

Between 1967 and 2009, hundreds of research projects and demonstration programs were implemented either under this general authority or in response to legislation passed by Congress mandating specific demonstration programs. Some of the innovative payment models that are still being discussed today were successfully implemented in Medicare demonstrations decades ago. For example, the 1991 Medicare Participating Heart Bypass Center Demonstration successfully reduced spending for heart bypass surgery using bundled payments for hospitals and physicians<sup>8</sup>, and the 2003 Acute Care Episode Demonstration successfully reduced spending for orthopedic and cardiac procedures through use of bundled payments.<sup>9</sup>

However, by the late 2000s, there was growing recognition that CMS had made too little progress in developing and implementing alternative payment models due to a number of statutory and funding barriers. Three of the most significant barriers were:

- **Limited funding to support demonstrations.** In FY2009, only \$30.2 million was appropriated to support the Research, Demonstration, and Evaluation program at CMS, a 78% reduction from the amount appropriated in 2001. In the 10 years between FY2000 and FY 2009, a total of \$817 million had been appropriated to support research and demonstration projects, representing an average of only \$82 million per year. This made it difficult to test multiple models or to implement Alternative Payment Models on a large enough scale to determine how they would work in different communities and in different types of provider organizations.
- **Statutory requirements for budget neutrality.** The statutory authority for most demonstrations required that Medicare spending be no greater than it would have otherwise been. This limited the ability to test payment models where expected savings were uncertain and to test preventive care models with the potential to achieve savings over longer periods of time. In some cases, budget neutrality meant that if the demonstration program failed to save money, payments to providers who were not in the demonstration would have to be cut to offset the losses.

- **Inability to make successful payment models broadly available.** Even if a demonstration showed that an alternative payment model had successfully reduced costs and improved quality, CMS had no ability to make it broadly available to healthcare providers unless Congress passed legislation specifically authorizing the use of that payment model. For example, even though the Heart Bypass Center Demonstration showed that cardiac surgery bundles could successfully reduce costs without harming quality, the program ended in 1996 and neither the participants nor any other physicians and hospitals were able to be paid that way for the next two decades.

In 2010, as part of the Affordable Care Act, Congress created the Center for Medicare and Medicaid Innovation (CMMI)<sup>10</sup> and gave it powers and resources specifically designed to overcome these problems:

- **A large, multi-year appropriation.** The Affordable Care Act appropriated \$10 billion to CMMI for the 10-year period from FY2011 through FY2019, and it appropriated an additional \$10 billion for each subsequent 10-year fiscal period beginning with FY2020. This represented a more than 10-fold increase over the appropriations that had been available during the previous decade.
- **No requirement for initial budget neutrality.** The statute explicitly states that “The Secretary shall not require, as a condition for testing a model...that the design of such model ensure that such model is budget neutral initially...” Instead, the law requires that the Secretary of HHS terminate *or modify* the design and implementation of a payment model if, *after testing has begun*, the model is not expected to either reduce spending or to improve quality without increasing spending.
- **Ability to allow additional providers to participate in successful models.** The legislation explicitly allows the Secretary of HHS to “expand (including implementation on a nationwide basis) the duration and scope of a model ...if ...the Secretary determines that such expansion is expected to (A) reduce spending...without reducing the quality of care; or (B) improve the quality of patient care without increasing spending...”

# III. PROBLEMS WITH CMS'S CURRENT APPROACH TO CREATING APMs

The Center for Medicare and Medicaid Innovation (CMMI) began operations on November 10, 2010. In the seven years since then, it has spent over \$5 billion to implement more than 30 separate initiatives.<sup>11</sup> Although a number of innovative projects have been supported by CMMI, the overall results in creating effective Alternative Payment Models have been disappointing:

- Although many patients have benefited from enhanced and improved services, most of the Alternative Payment Models CMMI has implemented have not resulted in significant savings. One of the largest models implemented to date, the Comprehensive Primary Care Initiative, was not found to have achieved net savings, so it was discontinued and replaced by the Comprehensive Primary Care Plus demonstration.
- Only one of the models tested by CMMI has been expanded nationally (the Medicare Diabetes Prevention Program), and this model is not considered an “Advanced Alternative Payment Model” under CMS regulations.<sup>12</sup>
- As of the end of 2017, only five payment models created by CMMI met CMS requirements that would enable physicians to receive the higher payments authorized by Congress under MACRA. Most of the physicians who are participating in MACRA-eligible Alternative Payment Models are part of Accountable Care Organizations in the Medicare Shared Savings Program, not part of payment models created by CMMI.
- One-third of the more than \$5 billion spent by CMMI in its first six years was used for a variety of planning and technical assistance projects, not for Alternative Payment Models or projects that could serve as the basis for Alternative Payment Models.<sup>13</sup>

The disappointingly slow progress in implementing successful Alternative Payment Models means that each year, millions of Medicare beneficiaries are being denied the opportunity to receive higher-quality care and the Medicare program is spending billions of dollars more than is necessary.

*After seven years and \$5 billion in investment, only five payment models created by the Center for Medicare and Medicaid Innovation enable physicians to receive the higher payments authorized by Congress under MACRA.*

The lack of progress is due to several problems with the approach CMMI has used for developing and testing Alternative Payment Models:

## 1. Most of the APMs Being Tested Don't Solve the Problems with Fee-for-Service Payment

Most of the large Alternative Payment Models created by CMMI – the Bundled Payments for Care Improvement (BPCI) model, the Comprehensive Care for Joint Replacement Model, the Comprehensive ESRD Model, the NextGen ACO Model, and the Pioneer ACO Model – follow the same basic formula:

- **No changes are made in the current fee for service structure.** In most CMMI APMs, physicians, hospitals, and other providers continue to be paid under standard Medicare payment systems. No payments are made for any new services, even if those new services would be necessary or highly desirable in improving patient care and reducing avoidable spending.
- **Additional payments are dependent on achieving “shared savings.”** A year or more after services are delivered, the physicians, hospitals, or other providers in the APM may receive an additional payment (or be required to repay some of the payments they have already received) based on whether CMS determines that it spent less than it otherwise would have. This approach is essentially the same as CMS's pay-for-performance programs, except that the bonuses and penalties are proportional to the amount of money saved. This means that providers who already have high levels of performance receive no additional resources to sustain their operations, while providers who have had high rates of complications or who have overused expensive services can receive large bonuses for addressing those problems.

Adding “shared savings” on top of the current fee-for-service payment system does not solve the barriers in the current payment system that were described in Section I, since participating providers may or may not receive adequate or timely funding to support new high-value services that would benefit their patients. An even greater concern is that a shared savings program can financially reward a healthcare provider for failing to order or deliver a costly service that a patient needs, since the provider could receive a portion of the savings when fewer services are delivered.<sup>14</sup>

Moreover, the shared savings payment approach is already being used extensively for Accountable Care

Organizations as part of the Medicare Shared Savings Program (MSSP). Rather than trying to find significantly different approaches to Alternative Payment Models, CMMI has focused a large portion of its resources on developing and testing variations on the MSSP model. In fact, during the first six years of CMMI's existence, it spent over \$600 million on four different variations on the MSSP ACO model (Pioneer ACOs, NextGen ACOs, the ACO Investment Model, and the Advance Payment ACO model).<sup>15</sup>

Only two current CMMI Alternative Payment Models – the Comprehensive Primary Care Plus Model and the Oncology Care Model – provide significant new, upfront payments that are specifically designed to address barriers in the current fee-for-service payment system. However, continued payments under the Oncology Care Model are contingent on the oncology practice achieving savings. Even though CMMI tried using the shared savings model in the Comprehensive Primary Care Initiative and concluded that it was not an effective mechanism of paying physician practices<sup>16</sup>, it proceeded to use a similar shared savings approach to pay oncology practices as part of the Oncology Care Model.

## 2. Too Few Physician-Focused Payment Models Are Being Tested

Not only do the APMs developed by CMMI fail to solve the problems with fee-for-service payment while creating potentially problematic incentives to stint on care, most are designed in one or more ways that make it difficult for physician practices, particularly small physician practices and single-specialty practices, to participate.

- **No upfront payments for new or enhanced services.** Although upside-only shared savings models are commonly portrayed as “risk-free” for providers, the fact is that if the providers want to change the way they deliver care, they incur significant financial risk, since they have to pay for any new or enhanced services themselves and then hope that they will qualify for a large enough shared savings payment to cover those unreimbursed costs. This is particularly difficult for small physician practices and hospitals.
- **Eligibility limited to hospitalized patients, patients receiving expensive procedures, and complex patients.** Most of the CMMI models developed to date have focused on reducing spending after a patient has already been hospitalized (e.g., the Bundled Payments for Care Improvement initiative), reducing spending on patients who are receiving expensive outpatient procedures (e.g., the Oncology Care Model for chemotherapy and the Comprehensive ESRD Care model for dialysis), and reducing spending on complex patients with multiple health problems (e.g., Accountable Care Organizations). These models ignore the many opportunities that exist to reduce spending by preventing hospitalizations, using lower-cost alternatives to expensive procedures, and preventing the development and progression of chronic diseases. Moreover, by limiting alternative payment models to patients who receive expensive procedures, the CMMI

*Most of the APMs developed by CMMI fail to solve the problems with fee-for-service payment, they create potentially problematic incentives to stint on care, and they are designed in ways that make it difficult for physician practices and small providers to participate.*

models could unintentionally encourage delivery of unnecessary procedures.

- **Participation restricted to hospitals.** Even though physician practices have been successful in managing bundled episode payments for orthopedic and cardiac procedures in the private sector and in the Bundled Payments for Care Improvement initiative, CMMI has only permitted hospitals to participate in the Comprehensive Care for Joint Replacement (CJR) program, and the proposed CMMI Episode Payment program for cardiac procedures would have been open only to hospitals.
- **Requirements for large numbers of patients.** In many CMMI APMs, the minimum number of patients required for participation is far higher than the number of patients small physician practices care for.
- **Financial penalties for providers based on things they cannot control.** In most CMMI payment models, participating providers are rewarded or penalized based on whether the *total* Medicare spending on their patients is lower than expected, even if the providers have no ability to control or even influence all of the services their patients receive. For example, in the Oncology Care Model, oncologists could be penalized for increases in spending due to increases in drug prices, treatments for injuries their patients receive in car accidents, or complications of treatment delivered by other physicians for patient health issues unrelated to cancer, even though the oncologists could not reasonably be expected to control or even influence these aspects of total Medicare spending.<sup>17</sup>
- **Failure to risk adjust spending and quality measures based on clinical characteristics of patients that affect costs and outcomes.** A physician, hospital, or other healthcare provider can significantly influence the cost and quality of care through the decisions they make about how to treat patients and the way they deliver treatments, but they cannot control how sick or frail the patients who come to them for treatment are. The risk adjustment systems used in CMMI APMs fail to recognize many of the key patient characteristics that affect costs and outcomes, which means that providers who care for sicker or higher-risk patients can face financial penalties, which in turn could make it more difficult for such patients to obtain the care they need.<sup>18</sup>

Despite the fact that most of the healthcare services received by Medicare beneficiaries are delivered by non-primary care specialists, the CMMI Alternative Payment Model portfolio is almost devoid of models specifically designed for such specialists. In 2014, CMMI issued a Request for Information asking for input

on the creation of specialty-specific payment models<sup>19</sup>, and it convened several Technical Expert Panels to explore payment models in specialties such as cardiology, gastroenterology, neurology, and oncology. However, in the three years since then, CMMI has implemented only one APM – the Oncology Care Model – that was specifically designed for participation by small, non-primary care specialty physician practices.

In 2015, Congress recognized that CMMI had done too little to create Alternative Payment Models that were specifically designed for physicians. In the Medicare Access and CHIP Reauthorization Act (MACRA), it explicitly encouraged the development of physician-focused payment models (PFPMs) by:

- requiring the Secretary of Health and Human Services to establish criteria for PFPMs, including models for specialist physicians;
- authorizing individuals and stakeholder entities to submit proposals for PFPMs that meet these criteria;
- creating the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review these proposals and to prepare comments and recommendations to the Secretary regarding whether the proposals meet the criteria; and
- requiring the Secretary of Health and Human Services to publicly post a detailed response to the PTAC's comments and recommendations.<sup>20</sup>

In its initial year of operation, PTAC received dozens of proposals for physician-focused payment models, and in April 2017, only four months after receiving the initial proposals, the PTAC recommended two payment models for limited-scale testing.<sup>21</sup> These payment models would have enabled a wide range of specialists to participate in APMs that would improve care for a much broader range of patients than CMMI models. Unfortunately, the Secretary of HHS's responded that CMMI was unwilling to implement the models PTAC had recommended.<sup>22</sup>

### 3. The CMMI Testing Process is Slow, Burdensome, Expensive, and Discourages Significant Innovation

When CMMI decides to pursue development and testing of an Alternative Payment Model, the process it uses is extremely long, complex, and resource-intensive. This not only slows down the process of testing and implementation but it reduces the number of models that CMMI can or will test. Although many proposals for innovative alternative payment models have been submitted to CMMI, most have not been implemented even after many months of discussion with CMMI staff and despite efforts to modify proposals to address concerns raised by CMMI. Once CMMI decides to pursue a payment demonstration, it typically takes 18-24 months or more from the time an initiative is first announced to the time when providers actually begin to receive different payments. Even if a payment model is succeeding and other providers would like to participate, the evaluation process will take 3-5 years to complete before a decision is made as to whether a payment

model should be continued or expanded. As a result, under the current process for implementing APMs, it will likely take 6-8 years to make a desirable Alternative Payment Model broadly available.

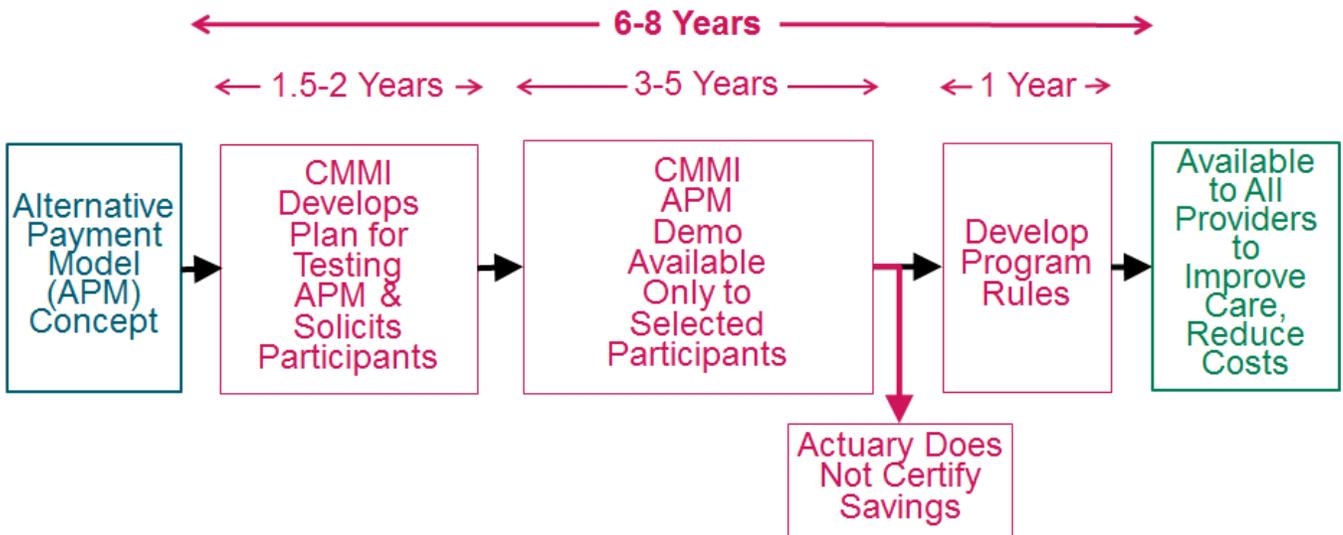
***Under the current CMMI process, it will likely take 6-8 years to make a desirable Alternative Payment Model broadly available.***

Providers report that the process of applying to participate in CMMI payment models is very burdensome. Providers are expected to complete lengthy application forms requiring submission of data and other information that is expensive and time-consuming to assemble, and applications may be rejected for failure to meet non-substantive requirements such as maximum page limits. Applicants may be required to respond within a few days to CMMI's requests for more information, but the applicants receive no commitment from CMMI as to when it will make a decision regarding their application. This uncertainty makes it difficult for a provider organization to know whether and when to start preparing for participation; starting preparation too soon could mean significant financial losses if the applicant is not accepted, whereas waiting until an application is approved to begin implementation planning could make it difficult for the provider organization to generate savings and quality improvements in the timeframes required in the demonstration.

Once accepted into a CMMI APM, providers are required to assemble and submit large amounts of data and to participate in a variety of meetings; these administrative activities can involve significant costs for providers and/or take significant amounts of their time away from patient care. There is generally little or no compensation provided to practices to offset these costs, even though CMMI spends tens of millions of dollars to pay the consultants who review the information the providers submit and organize the meetings they attend. Many providers, particularly small providers, have decided not to even apply to participate in otherwise desirable CMMI programs and others have dropped out of the programs in the early phases solely or partly because of the cost and time burden of participating.

Providers who do participate in CMMI payment models are told they can only count on the new payments lasting for a few years; the payments will only be continued beyond that if an evaluation proves that the program has saved money for the Medicare program. While this might sound like a very prudent approach, it can have the perverse effect of reducing the chances of significant success. Physicians, hospitals, and other healthcare providers are unlikely to fundamentally change the way they deliver care in response to a payment change that may only last a few years, and it is impossible to measure longer-term impacts on outcomes during an evaluation period that lasts only a few years.

## CURRENT CMMI PROCESS FOR IMPLEMENTING ALTERNATIVE PAYMENT MODELS



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# IV. HOW CMS CAN IMPLEMENT MORE SUCCESSFUL APMs MORE QUICKLY

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There are several things that CMS and CMMI could do to address these problems and to dramatically accelerate the implementation of APMs:

## 1. Embrace a Bottom-Up Approach to Payment Innovation at CMS

In its first seven years of operation, CMMI has taken a primarily top-down approach to designing APMs. Although it has nominally encouraged submission of proposals for APMs by physicians and other stakeholders, CMMI has only been willing to test or implement APMs of its own design. Moreover, there has been a clear bias toward payment models focused on groups of patients on whom Medicare spends large amounts of money and toward payment models that are difficult for small physician practices and small hospitals to implement.

For example, the first physician-focused payment model recommended by the PTAC was Project Sonar, a payment model that was developed by an independent gastroenterology practice in order to support better care management for patients with inflammatory bowel disease. Despite the fact that the payment model had already been implemented with commercially-insured patients with support from Blue Cross Blue Shield of Illinois, despite the fact that it had resulted in better patient outcomes and significant savings for the health plan, and despite the positive recommendation by PTAC, CMS declined to implement it, saying: “in lieu of testing the model as proposed...CMS [will] reach out to the Illinois Gastroenterology Group and SonarMD, LLC to involve them in HHS’ development of specialty models. As HHS develops potential models in this area, we will consider the input and insights from this proposal.” No indication was given as to when any such specialty models would be developed or implemented. Moreover, CMS suggested that spending associated with patients with inflammatory bowel disease was not large enough to warrant pursuing implementation of an alternative payment model to improve care for these patients, saying that “Patients with IBD accounted for only 1.25 percent of Medicare FFS spending.”<sup>23</sup>

As part of MACRA, Congress created a bottom-up approach that specifically welcomes APMs designed by physicians and other practitioners and that encourages development of APMs and delivery models that are feasible for small physician practices and small hospitals to implement. **CMS should embrace the process that Congress has created and commit to quickly implement all of the physician-focused Alternative Payment Models that are recommended by the Physician-Focused Payment Model Technical Advisory Committee.**

In addition, there are a number of communities across the country where physicians, hospitals, and other providers are working with patients, employers, health plans, and other purchasers to develop and implement alternative payment models to support high quality, more affordable care. However, it is difficult for them to successfully transform care delivery without participation by Medicare. Although CMMI has expressed a desire to support multi-payer APMs, the primary approach it has used to date has been to require local payers to conform to a structure CMMI defines, even if the payers and providers in a community have already implemented a different approach. Instead of the current top-down approach, **if a group of providers and payers in a state or region have developed or implemented an innovative APM, CMS should agree to implement a similar approach to paying for the care of Medicare beneficiaries in that community so that the providers can have full multi-payer support.** This was done in five states in 2011, when CMS agreed to participate in the Multi-Payer Advanced Primary Care Initiative, and a similar approach should be used in the future for APMs in specialty care and other areas.<sup>24</sup>

## 2. Create the Capacity at CMS and its MACs to Implement Bundled Payments and Other Alternative Payment Models

As discussed previously, almost all of the CMMI payment models implemented to date have been variations on the same “shared savings” approach. The reason why CMS and other payers have primarily used shared savings models is not because they are a good way to pay providers, but because they are very simple for a payer to implement. In a shared savings model, the payer doesn’t have to make any changes in the way it pays any providers for any of the services they deliver; all that is needed is for the payer to make a one-time retrospective comparison of actual vs. expected spending to determine whether the provider should receive a bonus or penalty. As described earlier, however, what is simple for payers is problematic for providers, since the shared savings model not only fails to remove the barriers in the fee-for-service system, it creates significant financial risk for small providers who want to deliver new and innovative services, and it creates troublesome financial incentives for providers to withhold care that patients need.

Similarly, the payment models favored by CMMI that hold providers accountable for total Medicare spending are much easier for CMS to implement than models where accountability is focused on specific types of services or health conditions. However, payment

models based on total spending inappropriately place small providers and single-specialty providers at significant financial risk for things they cannot control and can discourage providers from treating patients with unusual or complex needs.<sup>25</sup>

In contrast, a good alternative payment model will have the following characteristics:<sup>26</sup>

- **Adequate resources to support the services patients need.** Since the current fee-for-service system does not pay adequately or at all for many high-value services (e.g., communication among physicians to resolve a diagnosis or coordinate services, proactive outreach to patients to identify problems early, etc.), successful alternative payment models need to provide additional resources to deliver these services in order for providers to reduce the use of other, more expensive services.
- **Flexibility for providers to deliver the most appropriate services.** In a successful alternative payment model, a provider or team of providers would not be penalized financially for choosing the best combination of services for their patients.
- **Accountability for the aspects of quality and spending that the provider can control.** In return for adequate, flexible payments, a provider can accept accountability for improving quality and reducing costs, but the accountability needs to be focused on the types of outcomes and spending that the provider can control. In addition, both accountability measures and payment amounts need to be adjusted for differences in patient characteristics that affect outcomes and costs.

There is no single alternative payment model with these characteristics that will work for all types of patients and all types of healthcare providers. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs will differ for the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities will also differ by specialty, as will the barriers in the current payment system that need to be overcome in order for physicians, hospitals, and other healthcare providers to redesign care delivery for their patients.

However, a relatively small number of alternative payment model structures will likely enable most physician practices and other providers to address the vast majority of patient needs. For example, the American Medical Association has identified seven types of physician-focused Alternative Payment Models that can be used to address the most common types of opportunities and barriers that exist across all physician specialties.<sup>27</sup> These are:

1. **Payment for a High-Value Service.** Under this APM, a physician practice could be paid for delivering one or more desirable services that are not currently billable, and in return, the practice would take accountability for controlling the use of specific types of avoidable services for its patients.

2. **Condition-Based Payment for Physician Services.** Under this APM, a physician practice would receive a bundled payment that provides the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the practice.
3. **Multi-Physician Bundled Payment.** Under this APM, two or more physicians who are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
4. **Physician-Facility Procedure Bundle.** This APM would allow a physician who delivers a procedure at a hospital or other facility to choose the most appropriate facility for the treatment and it would give the physician and facility the flexibility to deliver the procedure in the most efficient and high-quality way.
5. **Warranted Payment for Physician Services.** This APM would give a physician practice the flexibility and accountability to deliver care with as few avoidable complications as possible.
6. **Episode Payment for a Procedure.** This APM would enable a physician who is delivering a particular procedure to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.
7. **Condition-Based Payment.** Under this APM, a physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers who deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition. Condition-based payments are the most patient-centered payment models and provide the greatest opportunities to improve outcomes and control spending.<sup>28</sup>

Many payers, including CMS, claim they cannot implement these types of bundled payments and alternative payment models because their current claims payment systems do not support them. But failing to make investments in the administrative systems needed to implement new payment models is penny-wise and pound-foolish, because the potential savings from better payment models will far exceed the costs of implementing them.

**CMS and its Medicare Administrative Contractors (MACs) should quickly make any changes needed in Medicare claims payment and other administrative systems to support implementation of all seven of these alternative**

**payment model structures.** This would not only ensure that CMS can quickly implement a wide range of proposed APMs, but it would encourage physician practices, medical specialty societies, and others to design payment models in a common framework, which will reduce implementation costs for CMS and other payers.

In addition, **CMS should revise the definition of “financial risk” in the MACRA regulations to enable design of Advanced APMs that small physician practices can feasibly participate in.** In MACRA, Congress required that in order for a physician to be exempt from MIPS and to qualify for the bonus payments authorized by Congress, the entity receiving the payment must bear “financial risk for monetary losses ... that are in excess of a nominal amount.” The risks incurred when a physician practice participates in an alternative payment model are a function of both the *costs that the practice incurs to implement the model and the revenues it receives under the model.* If the practice hires or pays for new staff to deliver services to patients under the alternative payment model, if it acquires new or different equipment to deliver services, or if it incurs increased administrative expenses to implement the alternative payment model, and if those expenses are not automatically or directly reimbursed by Medicare, then the practice is accepting financial risk for monetary losses. Therefore, CMS regulations defining the practice’s risk should be revised to include consideration of the increased costs a practice incurs, not just increases in Medicare spending. CMS should also lower the requirement that a practice pay CMS as much as 8% of its revenue when spending increases, since that represents *substantial* financial risk, not just “more than nominal risk.”

Moreover, a physician practice that agrees to participate in a new APM that involves delivering care in new ways and new methods of payment is inherently incurring significant financial risk to do so. Consequently **CMS should designate any APM that is undergoing testing by the Innovation Center as an “Advanced” APM.**

### 3. Use Limited Scale Testing to Accelerate Innovation

Although most good alternative payment models will likely look like one of the models in the seven categories above, the detailed parameters of the model – the payment amounts, the specific services included and excluded, and the accountability measures – will differ depending on the specific patients, conditions, services, and communities where the model will be used. For example, although oncologists and cardiologists could each use a form of condition-based payment to improve care for their patients and reduce spending for Medicare, the types of treatments that will be paid for and the outcomes to be achieved will differ significantly between patients with cancer and patients with heart failure, and so the payment amounts and performance measures in the APMs will also need to be different.

In most cases, however, providers face a “chicken and egg” conundrum in defining an Alternative Payment Model for specific types of conditions, procedures, and

patients. Fully specifying the parameters of the APM requires information that can only be obtained from providers who are delivering services in a different way, but providers cannot deliver services in that way without having an alternative payment model to support them. For example:

- **Determining appropriate payment amounts for new or different services.** If an APM is going to support the delivery of a service that is not currently eligible for payment under current Medicare payment systems, the APM will need to specify how much will be paid for that service. However, it is difficult to estimate the cost of such a service if there is little or no experience in delivering the service due to lack of payment. For example, a payment model might be designed to pay a non-clinician educator to help a chronic disease patient learn how to avoid exacerbations, but it will not be clear how many patients can be adequately educated by a single individual, how much will need to be paid for an educator with the skills necessary to be effective, etc. until the APM is actually implemented.
- **Setting payment amounts for bundled services.** If an APM provides a bundled payment that replaces one or more current Medicare payments and also provides flexibility to deliver services that are not currently eligible for payment, the APM needs to specify how much will be paid for the bundle. However, it is difficult to estimate the appropriate payment amount without an understanding of how often current services would be replaced by new services, the extent to which fixed costs supporting existing services can be eliminated, etc. For example, many physicians would prefer an APM that replaces current Evaluation & Management payments (which are limited to face-to-face visits with the physician) with a monthly payment that would provide the flexibility to schedule patient phone calls with the patient instead of just office visits, to make contacts with patients using nurses instead of just the physician, etc. However, it will not be clear how much these monthly payments should be until it is determined what proportion of office visits can be eliminated, what types of additional staff the practice needs, etc., and those changes cannot be made until the APM is actually implemented.
- **Defining methodologies for risk-adjusting/stratifying payments.** An APM that creates a bundled payment in place of fees for individual services will likely need to stratify or adjust the bundled payment amount to reflect differences in patient needs. However, the patient characteristics that affect the level of services may not be adequately captured by ICD-10 diagnosis codes. The APM would need to specify what combination of patient characteristics would be associated with each payment stratum and how much the payment amount would be, but it is difficult to do either of these things without data on how many patients have particular combinations of characteristics and how the appropriate services will differ for different characteristics. For example, an APM might create a monthly payment to support home-based palliative care services to patients, but the payment amounts would need to be higher for patients with

lower functional status, less caregiver support, etc., and it will not be clear how many patients have those characteristics and how many patients in each category could be managed by a palliative care team until the APM is actually implemented.

- **Setting standards for performance on outcomes.** There is broad agreement that it would be desirable to have APMs that are designed to improve patient outcomes. However, there is little outcome data available that can be used for establishing baseline levels of outcomes and performance standards because of the significant costs involved in collecting outcome data and the lack of a business case for providers to incur those costs under current payment systems. For example, an APM might provide a flexible payment for managing knee or hip osteoarthritis that encourages use of alternatives to surgery; the APM would need to hold providers accountable for addressing pain and mobility problems in order to ensure they were not stinting on services, but data on expected levels of pain and mobility would not be available until they were collected through implementation of the APM.

Currently, CMMI will only test a payment model if it projects that the model will reduce Medicare spending. However, since it is impossible to confidently make such a projection without specifying the parameters of the model, CMMI's current approach means that most innovative models will never be tested.

To address this problem, **CMMI should create a process for "limited scale testing" of innovative alternative payment models.**<sup>29</sup> The following five-step process could be used for this:

#### 1. Selection of Pilot Sites for Limited-Scale Testing.

When CMMI is presented with a proposal for a promising Alternative Payment Model (e.g., a proposal that has been recommended by the Physician-Focused Payment Model Technical Advisory Committee) where the information needed to fully specify the parameters or to estimate impacts cannot be obtained without implementing the APM on a limited scale, CMMI would issue a public call for physician practices or other provider organizations to volunteer to serve as pilot test sites. It would then select a small group of the volunteers who: (1) could collectively serve a sufficiently large number of eligible Medicare beneficiaries to provide reasonably reliable data for setting the APM parameters; (2) are reasonably representative of the diversity of practice structures that would be eligible to participate in the APM if it were made widely available, (3) are located in different parts of the country that differ in terms of market structure, practice patterns, etc., and (4) are willing to collect the data necessary to set the APM parameters and to participate in a formative evaluation process.

- #### 2. Implementation of the APM at the Pilot Sites.
- CMMI and the pilot sites would agree on a set of initial "best guesses" for the APM parameters. The pilot sites would start delivering care as the APM intended, they would assess patients and assign them to payment categories using the initial

definitions of those categories, and they would bill CMS for payments under the APM using the initial amounts. There would be an explicit understanding that the payment amounts would probably not be "right" initially, and so there would be a collaborative effort between CMMI and the pilot sites to assess the payment parameters frequently during the limited-scale testing process and to adjust the parameters as necessary in order to ensure that patients are receiving high-quality care and that the pilot sites are neither being financially harmed nor receiving financial windfalls at Medicare's expense. This would be consistent with CMMI's commitment to rapid cycle evaluation of payment models.

- #### 3. Collection of Data for Refining Parameters.
- The pilot sites would collect data on the time and resources involved in providing services to the patients, information on patient outcomes, etc. in order to refine the model parameters. Ideally, all or part of the cost of the data collection activities would be covered using funds or other assistance provided by CMMI.
- #### 4. Decision About Broader-Scale Testing or Implementation of a Refined Model.
- Following a period of limited scale testing, a decision would be made by CMS as to whether to pursue testing of a revised version of the APM with sufficiently broad participation to enable a summative evaluation of its impact on spending and quality. This decision would be based on the results of the formative evaluation as to the desirability of the APM for patients, for physician practices, and for CMS. In some cases, the benefits of the APM in terms of savings and quality improvement will be sufficiently large that it will be appropriate to immediately make the APM available to all interested providers and then monitor and refine it over time.
- #### 5. Transition of Pilot Sites.
- In order to encourage providers to serve as pilot sites, CMS should make a commitment to them that if a decision is made to terminate continued development and testing of the APM, a plan will be developed that would enable the pilot sites to transition out of the limited-scale testing process and return to standard payment systems without incurring any financial losses.

CMMI's authorizing statute clearly permits this type of limited-scale testing. There are no limits in the law as to (1) how many providers can participate in testing, (2) how the evaluation should be conducted, (3) how quickly a determination must be made as to whether the model improves quality or reduces spending, or (4) how often the design of a model can be modified before it is terminated or expanded. In fact, CMMI is prohibited from requiring that a model be designed to be budget neutral initially, and the law authorizes CMMI to modify the design and implementation of a model after testing has begun if the model is not expected to either improve quality without increasing spending or reduce spending without reducing quality.

Moreover, CMMI has already demonstrated the ability to simultaneously implement limited-scale testing for large

numbers of care delivery improvement projects. Through two rounds of Health Care Innovation Awards (HCIA) in 2012 and 2014, the Innovation Center awarded grant funds to support the implementation of 146 pilot projects testing innovative approaches to care delivery across a wide range of medical conditions.<sup>30</sup> Many of the HCIA awards demonstrated that significant improvements in quality and reductions in spending were possible if healthcare providers could receive the resources they needed to deliver care differently. However, none of the HCIA awards involved implementing a payment model that would enable continuation of the approach developed in the project beyond the award period or the expansion of the same approach to other sites. Moreover, while the HCIA grant funds could enable providers to pay for services that are not reimbursable under the fee-for-service system, the grants did not eliminate the financial penalties providers would face if they reduced reimbursable services. Therefore, it is essential for CMMI to expand the use of limited-scale testing to Alternative Payment Models.

#### 4. Create a Faster, More Efficient Approach for Implementing APMs

As noted earlier, the current process CMMI uses to design and test an Alternative Payment Model takes approximately 6-8 years to complete. Moreover, CMMI has only been able to initiate testing of a few APMs each year because of the elaborate and expensive structure of monitoring and evaluation contractors and learning networks for providers that it creates for each APM. As of September, 2016, more than half of the funds spent from CMMI's appropriation had been used to pay for planning, research, evaluation, and technical assistance activities, rather than for payments to providers to improve the delivery of care.

If CMMI continues to use this same process for testing and implementing alternative payment models in the future, it would take a decade before the majority of physicians in the country would have the ability to participate in an APM designed for the types of patients they care for. This would also mean that relatively few Medicare beneficiaries could benefit from the higher quality care that would be possible under APMs and that the Medicare program would not achieve the significant savings that wider use of APMs could generate.

**CMMI should completely redesign the processes it uses to test and implement alternative payment models in order to achieve the goals that are implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from well-designed alternative payment models in 2019, at least 50% of their revenues from APMs in 2021, and at least 75% of their revenues from APMs in 2023.**

Just as many physicians, hospitals, and other healthcare providers are now re-engineering their care delivery processes to eliminate steps that do not add significant value, CMMI should use Lean design techniques and other approaches to identify and eliminate all steps and requirements in its implementation processes that do

not add value or that impede achieving the goals that Congress has set. Moreover, reducing the number of consulting contracts on projects will free up CMMI staff time and funds so that more APMs can be implemented simultaneously.

As part of the redesign process, CMMI should also look for ways to reduce the administrative requirements it has imposed on providers participating in APMs. As noted earlier, the administrative burdens in many existing models discourages participation, particularly by small providers, and the burdens reduce the ability of providers to make the care improvements needed to achieve success under the APM.

**To ensure that the MACRA goals are achieved, CMS should establish specific milestones that are designed to implement as many proposals for alternative payment models as possible and as quickly as possible.** For example, the following timetable would allow alternative payment models to be made broadly available within 2-3 years after a proposed APM model is submitted to CMMI:

- When a desirable APM is proposed (e.g., when a physician-focused alternative payment model is recommended by the PTAC), CMMI should recruit and select initial pilot sites within 90 days.
- CMMI should then work collaboratively with the pilot sites to develop the initial parameters for implementing the APM. This process should not take more than six months.
- Over the next 12 to 24 months, the pilot sites would be paid through the APM and use the new payments to restructure the way they deliver care. CMMI and the pilot sites would work together to continuously refine the details of the APM to ensure it results in a “win-win-win” for the patients, the pilot sites, and the Medicare program.
- Assuming the results produced at the initial pilot sites confirm the desirability of the APM, CMMI would then develop the rules and procedures needed so that a larger number of providers could apply to participate in the APM. This would be completed within 6 months.
- Interested providers should then be permitted to apply to participate in the APM no less frequently than twice per year. Applications to participate should be reviewed and approved or rejected by CMMI within 60 days. Applications should only be rejected if an applicant cannot demonstrate that it has the ability to implement the APM, not because of arbitrary limits on the size of the program.

Once a provider begins to participate in an APM, they should be permitted to continue doing so as long as they wish to, unless CMS can demonstrate that Medicare spending under the payment model is higher than it would be under the standard physician fee schedule or that the quality of care for beneficiaries is being harmed.<sup>31</sup> It is unlikely that providers will be willing to implement significant changes in care delivery if they believe the APM will only be available for a short period of time and that they will have to dismantle the changes they have made when the demonstration project ends.

In many cases, there may be no need for additional “testing” of a model before it is made broadly available to providers who wish to participate. If an APM is explicitly structured to assure CMS that Medicare spending would be lower than it would otherwise be, if sufficient data exist to set the parameters of the model, and if a large number of physicians, hospitals, and/or other providers want to participate in the APM, then it would be in the interests of beneficiaries and the Medicare program to allow as many providers to participate as are willing to do so.

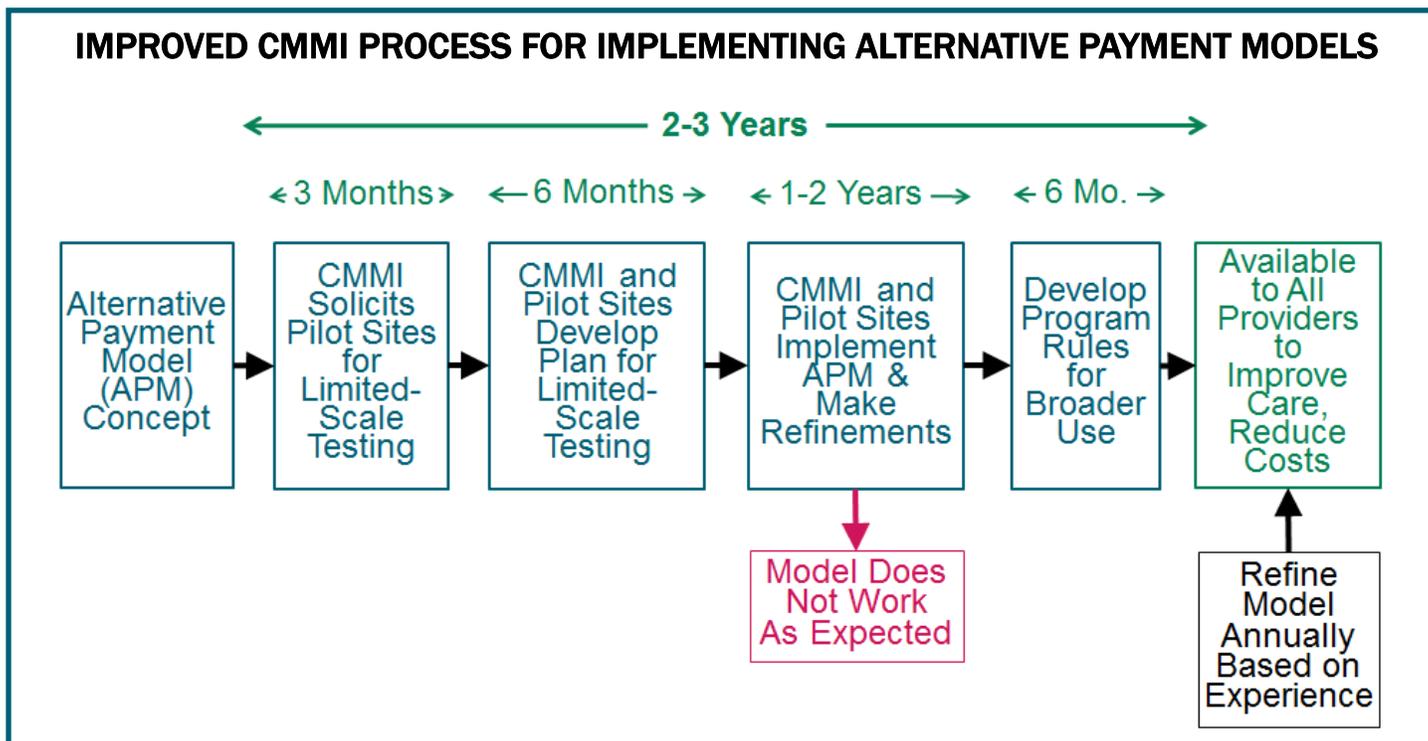
Implementing new payment models without a formal evaluation is hardly unprecedented. All three of the principal payment systems that Medicare currently uses to pay physicians and hospitals were implemented without waiting for an evaluation of a demonstration:

- The Inpatient Prospective Payment System (i.e., hospital DRGs) was designed and implemented for most hospitals across the country in 1983 without any evaluation demonstrating that it would work. It was implemented nationwide just 14 months after Congress passed the authorizing legislation.<sup>32</sup>
- The RBRVS Physician Fee Schedule was implemented for all physicians beginning in 1992 after it was mandated by Congress in 1989, with no demonstration or evaluation of the payment system before it was implemented.
- The Outpatient Prospective Payment System was implemented in 2000 to pay hospitals for outpatient procedures, with no testing or evaluation prior to implementation.

Instead of being “tested” in an artificial demonstration, all of these payment systems were made available nationally in a phased but rapid approach. They were then monitored and regularly adjusted to correct any unanticipated problems and to adapt the payment systems as changes in science, technology, and other factors occurred over time.

Similarly, new Alternative Payment Models could be implemented and then monitored and regularly adjusted to correct any unanticipated problems and to adapt them as new technologies and research results appear.<sup>33</sup> If at any point, CMS identifies a situation where quality is being harmed for a particular physician’s patients, or where spending is not truly being reduced, that physician’s participation in the payment model could be terminated, similar to what CMS can do today in its standard payment systems.

However, similar to the way Congress established the Medicare Shared Savings Program, physicians, hospitals, and providers should have the choice of whether to participate in APMs or to continue delivering services under the standard fee-for-service payment system. Not every physician or hospitals would need to participate in an Alternative Payment Model in order for the Medicare program to achieve significant savings, and it is likely that better results will be achieved by willing participants than by those who are forced to participate.



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# V.

## THE URGENT NEED FOR A NEW APPROACH TO INNOVATION

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When the Center for Medicare and Medicaid Innovation was created in 2010, the serious problems with the fee-for-service system were only beginning to be recognized and there was little agreement on what “value-based payment” should be. In that context, CMMI had to take the initial steps on its own to define and implement new payment models, and it is not surprising that it would proceed slowly and carefully to determine how to do that.

In contrast, there is now widespread agreement that alternatives to fee-for-service payment are essential for improving the quality and controlling the costs of healthcare, and there is increasing recognition that current approaches to value-based payment have had disappointing results and the results are not likely to improve in the future. Even more significantly, a growing number of providers now see alternative payment models as an opportunity to deliver better care for their patients in a more financially sustainable way. Many physician practices, hospitals, medical specialty societies, and other stakeholders are actively working to develop Alternative Payment Models designed to support the specific kinds of care their patients need to achieve better outcomes at a lower cost. Finally, the increasingly serious problems that rapidly escalating healthcare costs are causing for patients, employers, and taxpayers has created an urgent need for faster progress in implementing alternative payment models that will enable physicians, hospitals, and other healthcare providers to deliver better and more affordable care.

Congress gave the Center for Medicare and Medicaid Innovation both the statutory authority and the financial resources needed to rapidly develop and implement a wide range of truly innovative payment reforms. It is time for CMMI to radically redesign its processes so it can implement a larger and more diverse set of Alternative Payment Models far more quickly than it has in the past. This will enable CMMI to serve as the collaborative partner that is badly needed by the many physicians, hospitals, other healthcare providers, and other stakeholders who are developing innovative approaches to healthcare payment and delivery in order to create a better and more affordable healthcare system.

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# ENDNOTES

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1. For example, there is generally no payment or inadequate payment for (1) responding to a patient's phone call about a symptom or problem, (2) communications between primary care physicians and specialists to coordinate care, (3) communications between community physicians and emergency physicians when a patient comes to the emergency department, (4) proactive telephone outreach to high-risk patients, (5) shared-decision making processes with patients and families, (6) patient education and self-management support by nurses, diabetes educators, etc., (7) home-based palliative care, or (8) non-healthcare services, such as transportation to a physician's office.
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3. Miller HD. *Implementing Alternative Payment Models in MACRA*. Center for Healthcare Quality and Payment Reform (January 2016). Available at: <http://www.chqpr.org/downloads/ImplementingAPMsUnderMACRA.pdf>
4. Centers for Medicare and Medicaid Services. *Quality Payment Program: APMs Overview*. Available at <https://qpp.cms.gov/apms/overview>.
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6. In each of the first four years of the Medicare Shared Savings Program, the combination of the higher-than-expected spending by nearly half of the ACOs and the shared savings payments to the ACOs that earned such payments exceeded the amount saved by the ACOs that had lower-than-expected spending. Over the four year period, CMS spent a total of \$383 million more than it projected it would have spent if the program had not existed. *Medicare Shared Savings Program Accountable Care Organizations Performance Year 1 Results, Medicare Shared Savings Program Accountable Care Organizations Performance Year 2014 Results, Medicare Shared Savings Program Accountable Care Organizations Performance Year 2015 Results, and 2016 Shared Savings Program (SSP) Accountable Care Organizations (ACO) PUF* available at <https://data.cms.gov/browse?category=Special+Programs%2FInitiatives+-+Medicare+Shared+Savings+Program+%28MSSP%29>
7. 42 U.S.C. 1395b-1
8. Cromwell J, Dayhoff DA, Thoumaian AH. "Cost savings and physician responses to global bundled payments for Medicare heart bypass surgery." *Health Care Financing Review* 9(1):41-57 (1997)
9. IMPAQ International LLC. *Evaluation of the Medicare Acute Care Episode (ACE) Demonstration*. May 31, 2013 Available at: <https://downloads.cms.gov/files/cmml/ACE-EvaluationReport-Final-5-2-14.pdf>
10. 42 U.S.C. 1315a
11. Center for Medicare and Medicaid Innovation. *Report to Congress, December 2016*. Available at <https://innovation.cms.gov/Files/reports/rtc-2016.pdf>
12. Information on the Diabetes Prevention Program is available at <https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/>. The Office of the Actuary also certified the Pioneer ACO Model as eligible for expansion, but CMS has chosen not to continue the model.
13. Center for Medicare and Medicaid Innovation. *Report to Congress, December 2016*.
14. Miller HD. *Why Value-Based Payment Isn't Working, and How to Fix It*. Center for Healthcare Quality and Payment Reform (October 2017). Available at: <http://www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf>
15. Center for Medicare and Medicaid Innovation. *Report to Congress, December 2016*.
16. In the May 9, 2016 edition of "CPC+ Frequently Asked Questions," CMS stated "We have seen in the Original CPC Model that shared savings ...has certain limitations in motivating practices to control total cost of care. For example...total cost of care may be challenging for small primary care practices to control and there are no independent incentives for improved quality; and ....the amount of any shared savings payments is unknown in advance and the complexity of the regionally aggregated formula and paucity of actionable cost data leaves practices doubtful of achieving any return. The incentive payment methodology in CPC+ will address some of these limitations. The incentive design is stronger because it can be more closely measured at the practice level, will incorporate measures that primary care practices can directly impact, and will be more easily understood by practice leaders."
17. Polite BN and Miller HD. "Medicare Innovation Center Oncology Care Model: A Toe in the Water When a Plunge Is Needed." *Journal of Oncology Practice* 11(2): 117-119 (March 2015).
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19. <https://innovation.cms.gov/initiatives/Specialty-Practitioner/>
20. 42 U.S.C. 1395ee

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22. Comments from Secretary Thomas Price on Project Sonar, September 7, 2017. Available at <https://aspe.hhs.gov/system/files/pdf/257541/PTACProjectSonar.pdf> and Comments from Secretary Thomas Price on ACS-Brandeis Advanced Alternative Payment Model, September 7, 2017. Available at <https://aspe.hhs.gov/system/files/pdf/257541/PTACACS.pdf>
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27. Miller HD and Marks S. *A Guide to Physician-Focused Alternative Payment Models*. American Medical Association and Center for Healthcare Quality and Payment Reform. (November 2015) Available at: <http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf>
28. Miller HD. *Why Value-Based Payment Isn't Working, and How to Fix It*. Center for Healthcare Quality and Payment Reform (October 2017).
29. The Physician-Focused Payment Model Technical Advisory Committee has recommended creation of a limited-scale testing process for several of the payment models it has reviewed. Bailet J and Mitchell E. *Testimony to the Subcommittee on Health of the Committee on Energy and Commerce of the U.S. House of Representatives, November 8, 2017*. Available at: <http://docs.house.gov/meetings/IF/IF14/20171108/106599/HHRG-115-IF14-Wstate-MitchellE-20171108.pdf>
30. More information on the Health Care Innovation Awards is available at <https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/> and <https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html>
31. Section 1115A of the Social Security Act explicitly permits the Secretary of HHS to continue a payment model as long as the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. Moreover, if a payment model is not achieving these goals, the law gives the Secretary of HHS the power to modify the payment model rather than terminate it. Decisions to continue or modify a model can be made before an evaluation of the model is completed.
32. Although the Health Care Financing Administration (the predecessor to the Centers for Medicare and Medicaid Services) sponsored a demonstration project in New Jersey to pay hospitals under a DRG system, the demonstration was not completed or evaluated before the Inpatient Prospective Payment System was implemented nationally, and the DRG system used in New Jersey was significantly different from the system Medicare implemented nationally. Hsiao WC et al. "Lessons of the New Jersey DRG Payment System." *Health Affairs* 5(2):32-45 (1986). Smith DG. *Paying for Medicare: The Politics of Reform*. New York: Aldine de Gruyter (1992).
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