Americans Deserve to Get a Better Value From CMMI

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Abstract
The CMS Innovation Center was created in section 3021 of the Affordable Care Act (ACA) with the promise to test payment and delivery models expected to reduce costs while improving or maintaining quality of care for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries. Doug Badger’s analysis of the Center for Medicare and Medicaid Innovation (CMMI), published in Inquiry, described how the CMMI has failed to accomplish its goals and makes a case for reforms. As a practicing clinician in private practice who has followed the implementation of the components of the Affordable Care Act, including the CMMI, his conclusions are not surprising. An examination of the clinically unworkable and recently delayed Radiation Oncology Alternative Payment Model demonstrates serious flaws in current CMMI methods. Government agencies have difficulty directing innovation. Clinicians know that real innovation will arise in unpredictable ways from the ingenious communities, providers, and organizations that deliver the care. Innovation will occur when an atmosphere of transparency forces providers to respond to the demands of patients. The CMMI would do well to redesign its processes. If “value” is the goal of CMS, then America deserves a better “value” from its healthcare agencies.

Keywords
CMMI, innovation, alternative payment models, reform

Section: Health Financing—Editorial

CMMI—Promises Made, But Not Kept
The CMS Innovation Center was created in section 3021 of the Affordable Care Act (ACA) with the promise to test payment and delivery models expected to reduce costs while improving or maintaining quality of care for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries.1 Doug Badger’s analysis of the Center for Medicare and Medicaid Innovation (CMMI) published in Inquiry described how the CMMI has failed to accomplish its goals and makes a case for reforms. Despite 10 years and billions spent, the agency has failed to produce care delivery innovation that effectively reduces cost or address the most important health conditions.

What do we already know about this topic?
Doug Badger’s analysis of the Center for Medicare and Medicaid innovation (CMMI) published in Inquiry described how the CMMI has failed to accomplish its goals and makes a case for reforms. Despite 10 years and billions spent, the agency has failed to produce care delivery innovation that effectively reduces cost or address the most important health conditions.

How does this editorial contribute to this field?
My editorial expresses the opinion of an informed practicing clinician on the shortcomings of the CMMI and better directions for the agency moving forward. An examination of the clinically unworkable and recently delayed Radiation Oncology Alternative Payment Model demonstrates serious flaws in current CMMI methods. It also explains reason government has such difficulty directing innovation in the healthcare marketplace.

What are the implications of this editorial toward theory, practice, or policy?
Effective innovation will arise in unpredictable ways from the ingenious communities, providers, and organizations that deliver the care. The CMMI would do well to redesign its processes to embrace partnerships with the private sector and adopt policies that encourage an atmosphere of transparency and competition that forces providers to respond to the demands of patients. Specific suggestions are made by the author.

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Medicare and Medicaid innovation (CMMI) published in Inquiry described how the CMMI has failed to accomplish its goals and makes a case for reforms. As a practicing clinician in private practice who has followed the implementation of components of the Affordable Care Act, including the CMMI, his conclusions are not a surprise.

**Leading From Too Far Behind: Lag Indicators, Administrative Burdens, and Wasting Resources**

The CMMI website lists 98 separate models and the stage of development, delay, or cancellation for each. To begin a discussion of how these CMMI models can affect physicians attempting to work in them, it is timely to review recent developments in the long saga of one of those. On 08/26/2022, the Centers for Medicare and Medicaid Services issued a final rule to delay the start for its long promised CMMI Radiation Oncology (RO) Alternative Payment Model “to a date to be determined through future rule making.” CMS states it will delay the start and end dates of the model performance to a timeline “that will be established in future rule making.” At this point, this project has been in the making for nearly 10 years. This RO model was designed to test if a “site-neutral, perspective, episode-based payments to hospitals for nearly 10 years. This RO model was designed to test if a “site-neutral, perspective, episode-based payments to hospital outpatient departments, physician practice groups, and freestanding radiation centers would serve to enhance the quality of care while reducing or maintaining spending.” Since 2014, CMS has explored potential ways to test an episode-based model for radiation therapy services. In November of 2017, CMS issued report stating the reasons why radiation therapy was ready for payment and delivery service reform. My colleagues who provide RO services have been preparing for this APM ever since. Countless hours at professional meetings and in the administrative offices of oncology practices have been spent studying and preparing for the model and considering its operational impact. Envision blurry-eyed physicians listening to experts in conference rooms explain the details, bringing them back to their administrators, and asking them to spend valuable time to understand it. This most recent ruling prohibits implementation of the RO model before 01/01/2023 as part of the capitalized Protecting Medicare and American Farmers from Sequestration Cuts Act. Similar efforts have occurred across all medical specialties for decades as professional organizations, medical practices, hospital systems, and other stakeholders respond proactively to any number of proposals from CMS in areas of quality, value, and reimbursement.

**Clinically Unworkable Before It Began**

My RO colleagues tell me that this ruling by CMS to delay, rather than cancel the model, fails to recognize clinical realities. Advances in technology and clinical practice, which are improving outcomes and reducing harm to cancer patients, as well as complexities in local and regional delivery systems made the RO APM clinically unworkable long before it was scheduled to begin. Undaunted by this, CMS declined to cancel the model and continues to profess belief that it will “address longstanding concerns related to delivery and payment” for RO services. The model, therefore, hangs like a menacing specter over providers for the foreseeable future. I would argue that this disconnection between top-down, mandated, government-initiated attempts at innovation in care delivery and the clinical reality of practice is more the rule than the exception.

Studying the details of the radiation oncology model further reveals problems. The RO model is listed as “mandatory” and requires the participation from providers within randomly selected core-based statistical areas (CBSAs). The model design links payment to “quality reporting and performance measures,” clinical data reporting, and patient experience to determine payment. Note that one of the quality reporting methods specified is the CAHPS cancer care radiation therapy survey, an instrument closely related to the H-CAHPS and CG-CAHPS surveys. These cumbersome and ineffective instruments have their roots back in the 1990s with the CAHPS Consortium. Those of us practicing medicine are aware of the severe limitations of this type of quality reporting. Like many quality measures mandated by government, CAHPS fits distinctly into the category of a “lag indicator” which involve the retrospective collection or analysis of data long after the period of interest and not directly tied back to specific encounters. Although the CMS mandates for these measures created an entire industry to affect compliance, high quality providers today have virtually abandoned them in favor of much more effective means of patient engagement. These are one of many examples of administrative burdens developed and mandated by CMS in the name of quality or value which took much longer to create and prepare for than took them to become outdated and useless in practice.

**Advisors Canceled or Ignored**

To make the CMMI more accountable or responsive to real market conditions, the ACA included the creation of advisory committees. The Independent Payment Advisory Board (IPAB) would have consisted of 15 “wise people” with the “wisdom” to know how to cut Medicare payments (almost entirely through the physician fees schedule) while keeping the Medicare’s growth rate at predetermined levels. When it came time to appoint these 15 people, however, not a single person with qualifications was ever nominated, let alone appointed. Not surprisingly, the IPAB was repealed on a bipartisan vote of 307-111.

The act also created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to encourage stakeholders to engage with the development of alternative payment models. The mission of the PTAC is to make
comments and recommendations to the secretary of HHS on APM proposals. It remains unclear, however, what the impact of the PTAC has been. To date, there is little evidence that any of its recommendations have been adopted by the agency.

Lessons Learned or Just Failure Redefined

In the recently published “Innovation Center Strategy Refresh” document, CMS reports that it has “lessons learned” before outlining new objectives for the future. Those lessons include the need for streamlining the model portfolio to reduce complexity, create new tools to support transformation of care delivery, design models with broader provider participation, and use less complex financial benchmarks. In the “looking forward” section, the report claims “CMS Innovation Center enters the second decade with a solid foundation of models, results, and lessons learned that can be leveraged to achieve a bold, renewed vision by 2030.” Badgers’ policy brief outlines the falseness of that claim and raises questions about whether CMMI can be trusted with expanding on its vision. After 10 years and billions of dollars spent, CMMI has not made a dent in addressing care delivery for our most problematic health conditions. Clinicians know that solutions for those problems will not come in the form of government APM projects, designed far removed from actual delivery of care and out of touch with the demands of patients. Rather, they will arise from the complex and vibrant healthcare ecosystem of providers, hospitals, payers, and other stakeholders as well as the needs expressed by consumers. After so many years, it is distressing that CMS’s vision for CMMI still does not suggest partnerships with private sector providers and in fact, the “Refresh” document points that it is headed in the opposite direction.

Government and Innovation: Fundamental Problems

Government involvement in the process of innovation remains a controversial issue in economic markets. Instead of innovation, government involvement often delays innovation and subsidizes inefficiency. Regardless of lofty stated missions, government agencies are subject to the effect of special interests, the unintended effects of subsidies which can serve to protect inefficient providers, unsustainable distortions of price, restriction of competition, and the impacts of regulatory capture. Government regulation and bureaucracy is particularly damaging to the organic processes of innovation. The healthcare market is enormously complex and rapidly changing. I believe that solutions need to come from an open exchange of ideas, the processes of trial and error, increased transparency, and risk taking in the private sector. I also wonder whether a grant process, like that used for Small Business Innovation Research (SBIR), to support novel private sector initiatives might be effective. At this time, several large, high-quality health care systems (e.g., Geisinger, Inter-Mountain, and Kaiser) have spent decades trying to reduce costs and improve quality in their patient populations. Currently, there is little incentive for a given health care system to share the details of their “best practices” to manage chronic diseases without giving up a competitive advantage, or a government sponsored system to encourage ingenuity. Alternatively, government efforts to direct or create the usually unpredictable processes of innovation often result in the misallocation of resources or “crowd out” real ingenuity. CMMI projects such as the RO APM do not reflect the actual needs of our patients, the consumers, or the operational realities of practices. They also do not encourage real competition, which providers dislike, but is crucial to innovation. So, while the answers to improve health management reside in a vibrant and competitive private sector and a complex ecosystem of medical practices, facilities, and other enterprises, CMMI seems intent on avoiding real partnerships with those entities.

Quality, Value, and Equity: Bold Ideas Made Worse Than Worthless

Clinicians want to provide high-quality valuable care that efficiently serves our patients. We also want equitable access to everyone in our communities. However, perhaps the most compelling example of the disconnect between CMMI’s newly “refreshed” objectives and our clinical reality is in its new aim concerning “equity.” This is a clear injection of political ideology into healthcare delivery models. CMS has declared its aim “to embed health equity in every aspect of CMS innovation center models and increase focus on underserved populations.” These “historically underserved” populations “previously denied fair, just, and impartial treatment” are then expansively defined, not by health condition or objective limitations to healthcare access, but by race and gender identity groupings listed in Federal Government Executive Order 13985, Section 2(a), which includes essentially everyone other than urban or suburban, heterosexual, non-Hispanic whites. This represents a complicated new direction to be layered on top of an already struggling process. The additional steps specified to achieve this aim include collecting additional data about barriers to participation in these models for members of these populations, ensuring that all beneficiaries in these groups have access to providers engaged in the models, launching more “Medicaid-focused” models, modifying existing models to include more Medicaid beneficiaries, and requiring a more deliberate approach across CMS in measuring the impact of the models on these populations. Based on its history of ineffectiveness, it seems foolish to inject the undoubtedly significant additional administrative complexities associated with these goals into CMMI’s mission.
Americans Deserve Better Value From HHS

Badger’s policy brief outlines a history of failure by CMMI to produce scalable reforms, improve the efficiency of healthcare systems, reduce spending, or to enhance quality. After describing the extraordinary statutory authority given to CMMI under the statute, he makes the argument that healthcare reform should be the job of congress. While clinicians may be justifiably dubious of how effectively congress can be in that regard, we would expect CMMI to engage in real partnerships with the private sector and find better ways to accelerate the creation and sharing of innovation. Real innovation will arise from the bottom-up and in unpredictable ways from the ingenious communities, providers, and organizations that deliver the care. They will occur even faster when an atmosphere of transparency forces providers to respond to the demands of patients. The CMMI would do well to redesign its processes to accelerate those changes. My suggestions include direct grant support to aid the development and testing of innovative care-delivery models in the private sector, expanding the involvement of clinicians in model review and approval, and specifically setting goals to increase transparency and competition among providers. If “value” is the goal of CMS, then America deserves a better “value” from its healthcare agencies.

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