

The CMI would be charged with testing innovative payment and service-delivery models designed to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care — objectives that should have bipartisan support. Several aspects of the proposed CMI offer hope that this effort could be fundamentally different from previous Medicare-sponsored experiments.¹

First, the CMI would run pilot programs rather than demonstration projects. The proposal would give the secretary of health and human services authority to expand pilots that she determines would reduce spending or improve the quality of care. This provision is critical, because the need for congressional approval has delayed or derailed past initiatives. For example, in Medicare's heart-bypass demonstration project, in which a global fee was paid for services provided by hospitals and cardiac surgeons, participating providers improved the quality of care and reduced costs, but Congress never expanded it beyond the seven initial hospitals. Another demonstration project that tested competitive bidding for durable medical equipment between 1999 and 2002 reduced Medicare expenditures by 19% from what would have been paid under existing fee schedules. Although Congress authorized the CMS to expand the program, it delayed implementation until 2010.

Second, although the CMI proposal lists 18 payment or delivery models for consideration, the center would have broad authority to select the programs best suited to its objectives. In contrast, the CMS's Office of Research, Development, and Information has far less flexibility, because a large proportion of its resources are devoted to congressionally mandated projects.

A third critical difference is that the CMI would not have to require projects to be budget-neutral during their initial testing period. Many health care innovations require initial investments in staff, training, and infrastructure to achieve long-term efficiencies. But federal budget-neutrality requirements frequently discourage potential applicants, leave valuable concepts on the cutting-room floor at the Office of Management and Budget, and cut short promising programs that appear to be increasing Medicare costs. Finally, the proposal includes a \$10 billion appropriation for the CMI through 2019. This would allow the CMS, which has faced chronic shortages of administrative resources, to build the capacity necessary to manage the program effectively.² It would also allow the CMI to pay for services such as care coordination that aren't covered by traditional Medicare and to support activities such as electronic data sharing, performance measurement, and quality improvement at participating health care systems.

The CMI would encourage delivery innovation by creating alternative payment structures for organizations that are motivated to reduce clinical waste but that have been held back by the negative financial implications of doing so under fee-for-service reimbursement. The CMI could align Medicare payment with private initiatives such as the new quality-based global payment model that Blue Cross Blue Shield of Massachusetts has already implemented in contracts covering about 20% of the providers in its health-maintenance-organization network. Medicare participation would create a more uniform incentive structure for participating providers and magnify the potential rewards for success.

The CMI would have to prioritize its initial projects, and several concepts are particularly appealing. Many experts believe that Medicare payment must become more aligned with scientific evidence about what works. One opportunity for moving in this direction lies in having the CMI fund delivery systems' documentation of which care processes are the most effective for specific medical conditions. Having this information would help the CMS to develop payment policies that reward hospitals and physicians who follow best practices. One model described in the CMI proposal is a collaborative of health care organizations equipped with electronic records that could document and implement best practices and assist other institutions in employing them. In such a rapid-learning network, participants would embed decision support into their electronic health records to guide clinicians through specific care processes, document outcomes, report results, and adjust clinical practices on the basis of those results.³ Such a collaborative would also provide valuable information for the proposed national center for comparative-effectiveness research but would be fundamentally different, because the CMI would pay for clinical services, not just sponsor research.

A second opportunity is for the CMI to align Medicare payment with state and local reform initiatives. Individual states and most private payers do not have sufficient market power to implement payment reforms if providers are reluctant to participate. However, a Medicare waiver could allow states such as Massachusetts, which has proposed moving toward a global payment system, to establish a uniform structure of incentives that reward organizations for becoming more integrated and more accountable for cost and quality.⁴ Under such a system, providers who were prepared to accept alternative payment models would see payments increase, though perhaps at a slower rate than the current trend. Others could remain in the fee-for-service system but would face diminishing financial prospects.

Although pilot projects will not have much effect on national health care spending in the short run, they can encourage innovation in health care delivery by reducing or eliminating the link between service volume and provider revenue. The congressional proposals would reduce important historical barriers to innovation at the CMS, but success is ultimately about execution. The CMI would have to overcome a risk-averse CMS culture that promotes rigid adherence to rules. Although risk-averse behavior may be rational in a government bureaucracy, it often kills innovation.

What would it take to establish an effective innovation group within the CMS? The first step is to select a leadership team that understands health care delivery and federal government operations, thinks outside the box, and is willing to accept occasional failures as it pursues its objectives. The CMI will need a strategic plan with clear milestones and the ability to communicate skillfully with Congress. It will need to interact regularly with innovators and build on existing knowledge about what works. Regardless of the fate of national health care reform, Congress should try to enact some of the many good proposals developed over the past year that have bipartisan support. Successful innovation is essential to the long-term sustainability of Medicare and Medicaid. The CMI would cost relatively little in the context of the overall CMS budget, but if it were successful, the long-term effect on the U.S. health care system could be priceless.