Disrupting Care Decisions: How CMMI Overrides Patients & Providers

BACKGROUND

The Center for Medicare and Medicaid Innovation (CMMI) was established in the Affordable Care Act (ACA or Obamacare) in 2010. Designed to test new payment and delivery models – **at a cost of $10 billion per decade** to taxpayers – CMMI was intended to improve healthcare quality by streamlining care delivery and promoting value-based options. However, throughout its 15 years, it has done the opposite by wasting the taxpayer's money with **sweeping, nationwide policy changes** that **force providers and patients into mandatory changes** in care delivery with **no way to opt out.**

CMMI was supposed to save taxpayers $2.8 billion between 2011-2020 but lost $5.4 billion and is projected to lose another $1.3 billion by 2030. A 2021 analysis of 172 Medicare-related CMMI models revealed that only four met the criteria for expansion, and 15 percent decreased costs. **CMMI's failures prove once again why there should never be government-run healthcare.**

THE PROBLEM

CMMI wastes taxpayer funds on models that force standardized "one-size-fits-all" changes to patients' healthcare coverage, which often alter treatment plans and disrupt care.

By ignoring individualized needs, **CMMI undermines** personal decision-making and alters the quality of care without patient or provider consent. These disruptions could diminish treatment results in the long term and create billions of dollars in additional healthcare costs.

Exploited by unelected bureaucrats, **CMMI uses its models to unilaterally rewrite key parts of American healthcare policy** – bypassing Congressional authority and operating without the debate, transparency, or consent that the public deserves. Thus, **patients and providers are increasingly subjected to poorly designed care models that leave them worse off.**

Two examples of these wasteful concepts are the **Comprehensive Care for Joint Replacement model (CJR)** and the **Comprehensive Primary Care Plus model (CPC+).**

Comprehensive Care for Joint Replacement Model (CJR)

The CJR model was a **mandatory demonstration** that ran from April 1, 2016, through December 31, 2024, which required providers to take a fixed payment for an entire 90-day episode of care rather than getting paid separately for each service.

The model ran for eight years and **cost taxpayers $29 million. It forced thousands of caregivers and patients into a disruptive new payment system.**

The broad-scale demonstration yielded **no overall improvements in quality performance**. In fact, for two of the four measures of patient satisfaction, **performance scores were lower**. Furthermore, the CJR highlighted concerns that paying providers a single fixed amount **creates an incentive to stint on care, especially for sicker or more complex patients.**

In fact, the American Association of Hip and Knee Surgeons reported CMS's own findings in June 2022 that **"lack of risk adjustment in CJR likely drove selection bias against medically complex patients."**

The mandatory CJR model proved **particularly disruptive for smaller and rural hospitals**, illustrating how **CMMI's mandatory**, one-size-fits-all models can have unintended consequences. The agency later had to backtrack and make the model voluntary for these types of hospitals in November 2017, more than a year after the model's initial launch. The model was also not endorsed by the Department of Health and Human Services' Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Comprehensive Primary Care Plus (CPC+)

The CPC+ model illustrates how even models that CMMI labels as voluntary can be very disruptive to patients and their doctors. CPC+ was not only the largest primary care model tested but also the most expensive, costing taxpayers $2.8 billion, and **one of the most disruptive**.

Studies found that of the 27 quality-of-care measures examined, **CPC+ failed to improve any key measures of care**, including a lack of discernible changes in readmissions, unexpected hospital visits, use of low-value services, and overall comprehensive primary care. And most concerningly, patients experienced a **statistically significant decline in appropriate use of medications.**

Improvements in convenience and satisfaction within the model were found to be inconsistent across participating practices, suggesting that positive outcomes were likely driven by individual practice initiatives rather than the structural design of CPC+ itself. **This underscores that the model failed to achieve its intended goals of improving care quality, while imposing enormous costs on taxpayers.**

The CPC+ was also not endorsed by PTAC.

THE SOLUTION

We urge Congress to support the immediate suspension of all pending and proposed CMMI models. The best outcome for patients would be the elimination of CMMI. At the very least, Congress should establish clear, enforceable guardrails that significantly curtail CMS' misuse of mandatory models, protect patients' individual liberties and preserve their ability to choose the care that best meets their needs. By strengthening oversight and accountability, Congress can restore patients to the forefront of healthcare decision-making.

The disruption caused by CJR and CPC+ is just a fraction of the harm CMMI brings to patients and providers, exposing t**he broader problem: CMMI bureaucrats are overriding patient care, leaving taxpayers to fund models that give patients no say in their treatment options.**

American patients deserve high-quality care that fits their unique circumstances. Rather than continuing to fund a program that harms patients by disregarding their needs, it is critical that Congress redirect resources towards approaches that genuinely support patient choice, transparency, and better outcomes.