ous, policies focused on funding safety-net care may be supported. Interested states could consider two possible routes when submitting Medicaid waiver applications.

First, expansion of federal funding for uncompensated care pools has been a successful strategy for two states that didn't expand Medicaid and may be viable for both expansion and nonexpansion states. Under this strategy, funding for the care of undocumented immigrants is included under the umbrella of funding for low-income and uninsured populations.

Second, states could secure additional funding by testing new models of care delivery through the Medicaid Delivery System Reform Incentive Payment programs. Such programs have provided substantial federal funding for state safety-net initiatives, but they may be the more complicated option, since funding is temporary and must be budget-neutral for the federal government. Neither of these options addresses direct funding for outpatient care, which underscores the importance of recent Congressional action to temporarily renew federal funding for community health centers.

An audio interview with Dr. Kelley is available at NEJM.org

States' prerogative to act as innovators and experimenters is central to the history of health policy and federalism in the United States. At this critical moment, it remains to be seen whether the federal government will champion state flexibility even when states' proposed policies conflict with the administration's attitudes in controversial areas such as immigration. Innovations tailored exclusively to individual coverage for undocumented immigrants, such as reforms originally proposed by California, are most likely beyond reach. But preserving solvency for safety-net hospitals by securing funds for uncompensated care may be within the realm of possibility.

Disclosure forms provided by the authors are available at NEJM.org.

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Reform at Risk — Mandating Participation in Alternative Payment Plans

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In an ambitious effort to slow the growth of health care costs, the Affordable Care Act created the Center for Medicare and Medicaid Innovation (CMMI) and armed it with broad authority to test new approaches to reimbursement for health care (payment models) and delivery-system reforms. CMMI was meant to be the government's innovation laboratory for health care: an entity with the independence to break with past practices and the power to experiment with bold new approaches. Over the past year, however, the Department of Health and Human Services (HHS) has quietly hobbled CMMI, imperiling its ability to generate meaningful data on strategies for reducing spending on Medicare and Medicaid.

The controversy involves the abrupt termination (or, in one case, narrowing) of several "mandatory" payment programs. When it created CMMI, Congress aimed to overcome the obstacles that had impaired some of the earlier payment-reform efforts undertaken by the Centers for Medicare and Medicaid Services (CMS). In particular, CMMI was given the power to waive any part of the Medicare statute, parts of the Medicaid statute, and various antifraud provisions when designing its payment models. To insulate CMMI from the vagaries of the annual appropriations process, Congress supplied the agency with

a permanent appropriation averaging $1 billion per year. Most important, Congress gave the secretary of HHS the authority to expand a successful program "on a nationwide basis."

The fledgling agency moved carefully at first. Instead of requiring providers to participate in new payment programs, CMMI asked for volunteers. Many providers volunteered to become accountable care organizations, to develop patient-centered medical homes, and to accept bundled payments. Some of these approaches showed promise. The Pioneer Accountable Care Organization Model — under which groups of providers agreed to be "accountable" for the cost and quality of the care they provided and could then share in any savings generated — produced $118 million[1] to $280 million[2] in savings in its first year and an estimated $105 million in its second year.[3] The YMCA's Diabetes Prevention Program, which was tested under CMS authority, provided intensive lifestyle and dietary coaching to patients with prediabetes, which helped them lose weight and reduced hospital admissions. It, too, appeared to save money.

But CMMI soon came to appreciate the challenges involved in using volunteers to evaluate new programs. Organizations that volunteer to participate in alternative payment models are likely to be systematically different from those that don't sign up. They may be more organizationally sophisticated, more experienced with assuming risk, and better at adapting to such models — or, depending on the design of the model, they may be more likely to have high preparticipation baseline spending. A payment model that "works" for volunteer organizations might not work for other organizations, which is why voluntary programs don't always provide insight into whether a payment approach ought to be rolled out on a nationwide basis.

Making participation in a payment program mandatory allows the agency to correct for these selection effects. But such programs must be designed carefully. Conscripting all providers would eliminate the opportunity to have a control group, thus hampering evaluation of a payment model's causal effects. There are also problems associated with enlisting a randomly selected group of providers: forcing one provider — and not its competitor — into a payment program could put one or the other at a competitive disadvantage and could result in odd market dynamics. Given the choice, some patients might opt to go to a hospital that wasn't participating in a CMMI program, for example. This type of patient-level selection could skew evaluation. The better approach — and the one that CMMI has embraced — is to enroll all providers in randomly selected geographic areas in a given payment program, allowing providers in other areas to serve as controls. Such mandatory programs were also designed to enlist a large, diverse sample of providers in order to yield generalizable results.

In 2015, CMMI chose hospitals in specified regions to test bundled payments for hip and knee replacements. In 2016, the agency established a similar project for hip and femur fractures and for cardiac events. Mandatory payment programs were lauded in some quarters but provoked strong, organized opposition in others. Nearly 200 members of Congress and several provider organizations (including the American Medical Association, the American Academy of Orthopaedic Surgeons, and the Federation of American Hospitals) decried mandatory payment programs, with some calling them heavy-handed and others alleging illegality.

They found a receptive audience in President Donald Trump's first HHS Secretary, Tom Price, a former orthopedic surgeon and an unsparing critic of mandatory payment programs. On taking office, Price paused the Obama-era mandatory bundled-payment programs; some months later, he formally ended the programs for cardiac events and hip and femur fractures. HHS also sharply reduced the size of the program for hip and knee replacements, draining the study of much of its statistical power. Simultaneously, the agency announced that it would recommit itself to voluntary payment programs.[4]

The backpedaling is unfortunate and unnecessary. Mandatory programs are crucial tools for evaluating new payment models, and they stand on a solid legal foundation. When Congress vested CMMI with broad authority to test new payment models, it emphasized that it wanted the agency "to determine the effects of applying such models . . . on program expenditures . . . [and] quality of care." Why ask CMMI to measure the effects of new models, but deny it the authority to adopt the best available scientific methods? Even more fundamentally, Congress authorized HHS to adopt successful payment models nationwide. It would not have delegated to CMMI the extraordinary power to reshape Medicare and Medicaid while prohibiting the agency

from amassing the highest-quality evidence about which models are effective.

In addition, CMMI's authorizing statute prohibits the courts from reviewing the agency's "selection of organizations, sites, or participants." This provision also reinforces the conclusion that Congress meant to allow CMMI to insist on participation. What good would it do to prohibit volunteers from suing over their "selection"? They have, after all, volunteered. The prohibition makes sense only if Congress expected that some providers might be required to participate.

Statements from the nonpartisan Congressional Budget Office (CBO) confirm that Congress anticipated mandatory payment programs. In response to a question from then-Congressman Tom Price, the CBO wrote that its initial budget projections for CMMI "assumed that the center would conduct demonstrations using a broad array of innovative approaches" and that it "was not surprised when CMMI designed a demonstration in which participation was mandatory because that approach offers several important advantages."[3]

If the legal objections to mandatory payment programs are insubstantial, the federal government's decision to abandon such programs is difficult to defend. Without question, they are critical to developing robust evidence on strategies for cutting spending and improving quality. Current HHS Secretary Alex Azar testified before Congress that he is open to mandatory participation in new payment models. We believe he should follow through — or we will lose a key tool for learning new ways of constraining health care spending.

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Improving Adoption of EHRs in Psychiatric Care

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Psychiatric illnesses are common, disabling, and costly to patients, their families and communities, and the health care system. By 29 years of age, more than half of Americans will have had an impairing and clinically significant psychiatric illness, such as an anxiety disorder, a psychotic disorder, a substance use disorder, or major depressive disorder.[1] The Interdepartmental Serious Mental Illness Coordinating Committee — a new federal interagency committee authorized by the 21st Century Cures Act — delivered additional staggering statistics to Congress in December 2017.[2] The committee found that one in four adults with a serious mental illness has a coexisting substance use disorder, and one in six has misused opioids in the past year. People with psychiatric illnesses also have higher rates of coexisting medical conditions, lower life expectancies, and health care costs that are two to three times those of people without psychiatric illnesses.

The committee's report provides a blueprint for improving health care and quality of life for people with psychiatric illness. Its suggestions include promulgating evidence-based integrated health care, performance measurement, and early identification of disease. But a glaring omission in the report threatens to hinder many of the goals of the committee, the 21st Century Cures Act, and health care reform more broadly. Specifically, how will the federal government improve adoption of electronic health records (EHRs) in psychiatric care?

EHRs represent a key component of health care redesign. Their adoption in psychiatric care, however, lags far behind EHR implementation in the rest of medicine (see graphs).[3,4] As a result, psychiatric providers (including psychiatrists, psychologists, licensed clinical social workers, and counselors) often lack access to patient