Are We Really on the Road to Medicare Physician Payment Reform?

Christine Covert Cohn
Law Office of Christine Covert Cohn
Encino, CA

On March 1, 2013, President Barack Obama issued the much-anticipated sequestration order, officially cutting more than $85 billion from the 2013 federal budget, including approximately $11 billion in reductions from the Medicare program.¹ Following President Obama’s order, one week later, the Centers for Medicare & Medicaid Services (CMS) announced that payments for Medicare fee-for-service (FFS) claims with dates of service on or after April 1, 2013 would incur a 2% reduction in payment, after determining coinsurance, any applicable deductible and any applicable Medicare Secondary Payment adjustments.²

Spending on public healthcare programs has unquestionably contributed to mounting federal budget deficits. Historically speaking, the Medicare program has consumed an increasing share of the federal budget. Medicare expenditures rose from 3.5% of the federal budget in 1975 to 15.1% in 2010, and by 2020, Medicare is projected to account

¹ Sequestration Order for Fiscal Year 2013 Pursuant to Section 251A of the Balanced Budget and Emergency Deficit Control Act, As Amended, The White House Office of the Press Secretary, March 1, 2013, available at www.whitehouse.gov/sites/default/files/2013sequestration-order-rel.pdf (last accessed on Mar. 26, 2013); see also Memorandum for the Heads of Executive Departments and Agencies, Executive Office of the President Office of Management and Budget, March 1, 2013, available at www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-06.pdf (last accessed on Mar. 26, 2013). The sequestration order and its automatic across-the-board cuts resulted from the failure of the United States Congress Joint Select Committee on Deficit Reduction (also known as the “Supercommittee”) to reach a bipartisan agreement, in accordance with its mission under The Budget Control Act of 2011, Pub. L. No. 112-25 (BCA), on reducing the federal budget deficit by $1.2 to $1.5 trillion over ten years. Sequestration requires automatic cancellation of $85 billion in budgetary resources across the federal budget for the remainder of fiscal year 2013. (The cuts are automatic in the sense that Congress has not passed legislation that specifies the nature of the cuts with respect to any particular program.) The across-the-board cuts would have taken effect on January 2, 2013, but were delayed two months by The American Taxpayer Relief Act of 2012, Pub. L. No. 112-240. Certain programs are exempt from the cuts, including Social Security benefits and the Medicaid program.

for 17.4% of the federal budget. In 2011, overall Medicare spending grew at an annual rate of 6.4%, and spending on physician services grew at a rate of 4.8% per beneficiary. For the eight-year period from 2013-2021, the Medicare actuary has predicted a slower average annual growth rate of 6.1% in Medicare Part B expenditures. However, such projections of decelerated growth in Medicare spending assume that significant cuts will be made in Medicare physician payments, as mandated by the sustainable growth rate (SGR) formula.

How We Got Here: A Brief History of the SGR

Congress enacted the SGR as part of the Balanced Budget Act of 1997, in an effort to limit growth in Medicare spending on physician services to a “sustainable” rate, approximating the rate of overall economic growth. The formula takes into account such factors as inflation, projected per-capita growth in gross domestic product, the anticipated increase in Medicare Part B beneficiary enrollment, and costs associated with changes in law and regulation. If the cumulative rate of actual Medicare spending for physician services exceeds the target rate of increase for physician expenditures in a given year (or the SGR), the formula triggers a reduction in Medicare payments to physicians in the following year. Conversely, increases in payments would follow below-target expenditures in the previous year.

Actual physician-related spending has exceeded the spending targets every year since 2001 and the SGR has mandated negative updates for every year since calendar year (CY) 2002. That year, CMS implemented the 4.8% negative update for fees paid under the Medicare Physician Fee Schedule (MPFS), but Congress enacted legislation every

---

7 Pub. L. No. 105-33.
year thereafter to defer, at least temporarily, the SGR-scheduled negative update otherwise required under the SGR’s formula. In place of the SGR’s “mandatory” cuts, Congress enacted updates to the MPFS ranging from zero to 2.2%. Most recently, on January 1, 2013, Congress voted to delay the 26.5% negative update until the end of CY 2013.\footnote{The zero percent update for CY 2013 is set forth in Section 601(a) of The American Taxpayer Relief Act, Pub. L. No. 112-240, which amended Section 1848(d) of the Social Security Act, 42 U.S.C. § 1395w-4(d).}

To achieve budget neutrality, which prohibits revisions in CMS’ physician payment policy from producing any net increase or decrease in Medicare expenditures, the $25 billion cost of the most recent “doc fix” will be offset by cuts in Medicare and Medicaid payments to hospitals. As we know, for services rendered on and after April 1, 2013, this “zero percent update” has been eclipsed by the 2% cuts in physician payments under the sequestration order. But those cuts will occur as a result of the automatic across-the-board budget cuts mandated by sequestration, not by any alternative measure to control growth in Medicare physician payments, much less in the methodology that underlies determination of the rates set forth in the MPFS.

The annual SGR “drama,” including the regularity of down-to-the-wire doc-fix legislation in the past few years, has proven to be enormously frustrating to physicians, legislators, and policy analysts alike. Congress has been stymied, on the one hand, by a desire to avert disruption of beneficiaries’ access to their regular physicians that some policymakers believe would follow enforcement of the SGR’s rate cuts, and on the other hand, the disinclination to take responsibility for the large increases in federal spending that could flow from repeal of the SGR.

The SGR has itself been the focus of widespread criticism. It has been observed that because the formula is based on aggregate Medicare payments for physician services and sets changes in payment rates for all physicians, the SGR provides no incentive for any individual physician to try to restrain costs.\footnote{Paul B. Ginsburg, Rapidly Evolving Physician-Payment Policy—More Than the SGR, NEW ENG. J. MED., v. 364, no. 2 (Jan. 3, 2011); MedPAC, supra note 4, at 79.} Further, the uniform application of the formula to all specialties and geographic locations means that restraints on fee increases disproportionately burden those professionals who are relatively less able to
generate volume to compensate for lower fees.\textsuperscript{11} Others point out that the SGR merely sets a spending cap but does not compel anyone to address the underlying issues of volume, pricing of services, and health outcomes. Another point is that Congress has not provided for increased target levels of spending in line with its legislative overrides of the SGR’s mandated cuts. Consequently, the rate reductions required under the formula to recoup accumulated excess spending in previous years has vastly increased, which in turn has made enforcement of the SGR in subsequent years even more politically challenging.

The National Commission on Physician Payment Reform, the Medicare Payment Advisory Commission (MedPAC), and policy analysts and legislators have called for the repeal of the SGR.\textsuperscript{12} The accumulation of excess spending that would have to be recouped in the event of the SGR’s repeal has escalated the ultimate cost of repeal, both in terms of the potential political backlash as well as the impact on beneficiaries from the offsetting budget cuts likely to be applied to Medicare and other federal programs.

Given the potential costs of repealing or fixing the SGR in the current fiscal climate of huge federal budget deficits, Congress, at least up until now, has been unable to agree to adopt any proposal to permanently repeal or fix the formula. When the Congressional Budget Office (CBO) announced in February 2013 that it now estimates the cost of repealing the SGR and maintaining payment rates at current levels through 2013 would be $138 billion over ten years, it acknowledged the sharp decline reflected in that figure relative to the CBO’s previous estimate in 2012 of $248 billion. The CBO attributes the steep reduction in cost to lower spending on physician services in recent years.\textsuperscript{13}


\textsuperscript{13} Congressional Budget Office, \textit{The Budget and Economic Outlook: Fiscal Years 2013-2023}, at 31, available at \texttt{www.cbo.gov/topics/budget/budget-projections}; Congressional Budget Office, Update:
The cost of repealing the SGR thus may have fallen sufficiently enough to help revive legislative efforts to repeal it permanently. Indeed, new efforts are underway in Congress to repeal and replace the SGR with a new physician payment system, and there is broad agreement that, if it actually occurs, repeal of the SGR must be accompanied by changes in Medicare physician payment policy.  

Proposals abound for reforming the structure of the MPFS. Most of them include the recalibration of the formulas used to calculate physician payments and the incorporation of metrics that will, it is hoped, produce payments that take into account the quality and efficiency of the services Medicare pays for. In many (if not most) of these initiatives, e.g., per-episode payment, bundled payment, global payment, and accountable care organizations (ACOs), FFS payments will continue to play an essential role in determining the payment amounts that providers ultimately receive.

Given that FFS as a payment methodology will remain a significant component of physician payments, at least during the transition to new payment models and delivery systems that emphasize and reward improvements in quality and efficiency, and to fully

---


On April 4, 2013, Republican leaders of two House committees circulated an updated draft plan to permanently repeal and replace the SGR formula. (Representatives Fred Upton, Dave Camp, Joe Pitts and Kevin Brady, supra note 12.) Under this proposal, repeal and reform would proceed in three phases:

- Phase I features the repeal the SGR and fixed updates to the MPFS for a period of time (not yet determined) in which providers assess private sector and Medicare alternative payment models, and develop quality and efficiency measures and clinical improvement activities for purposes of Phase II.
- In Phase II, payments to providers will be based partly on the quality of the services rendered to Medicare beneficiaries. Payments will be comprised of a base rate and a variable, performance-based rate derived from the provider’s score on risk-adjusted quality measures and execution of clinical improvement activities.
- During Phase III, payment rates to physicians will continue to be based, in part, on risk-adjusted quality measures, and those who meet a minimum quality score threshold will be eligible to earn an additional incentive payments based on efficiency in the use of health care resources, which will take geographic variation into account.
appreciate and critically evaluate new payment methods, it is worth first taking a look at the prevailing methodology that forms the matrix of the MPFS.

**The Resource-Based Relative Value Scale System and the American Medical Association Specialty Relative Value Update Committee**

The foundation of the MPFS is the resource-based relative-value scale (RBRVS). The RBRVS determines the prices for physician services based on relative value units (RVUs), which measure the relative resources used to furnish each physician service. An overview of the RBRVS follows below, along with a brief description of the central role played with respect to the RBRVS by the American Medical Association (AMA) Specialty Relative Value Update Committee (RUC).

*Overview of the RBRVS and RUC*

The Medicare program first implemented the RBRVS and the physician fee schedule in January 1992, under the statutory authority of the Omnibus Budget Reconciliation Act of 1989.\(^{15}\) Congress adopted the RBRVS in the context of concern and dissatisfaction with the prior “reasonable charge” basis for physician reimbursement, which evidence suggested tended to encourage billing for highly paid services and to reinforce the uneven distribution of physician services in rural and urban areas.\(^ {16}\) The new system charged CMS with the task of determining, for each physician service, the RVUs for three types of resources: physician work (work RVUs), which encompasses the time, technical skill, physical effort, and mental effort and judgment required to perform the service; practice expenses (PE RVUs), which take into account all of the direct and indirect expenses incurred in furnishing the physician service (e.g., office rental expenses and wages paid to personnel); and malpractice insurance expenses (PLI).

---

\(^{16}\) Ginsburg, *supra* note 12.
Work and PE RVUs play the greater role. In 2010, the breakdown for the three types of RVUs comprising the performance of physician services was 52% work, 44% PE, and 4% PLI.\(^\text{17}\)

To reflect the costs for each type of resource in a geographic area relative to national average costs, the RVUs are adjusted by geographic practice cost indices. The adjusted RVUs are then transformed into a schedule of dollar amounts for each service by a conversion factor, which is calculated each year by the CMS Office of the Actuary. The conversion factor is updated each year in accordance with the SGR.\(^\text{18}\)

The RUC performs a critical function with respect to the RBRVS and the annual updates to the MPFS. The AMA established the RUC in 1991, originally for the purpose of advising CMS on the valuation of work RVUs. Since then, the RUC has taken on additional advisory tasks in connection with PE RVUs. The panel’s members are named by their national medical specialty societies. Representatives of the various medical specialties occupy 25 of the panel’s 31 seats, and 16 of the 25 spots are currently held by specialties whose physicians perform procedures or highly technical work, e.g., cardiology, dermatology, plastic surgery, radiology, and vascular surgery. Prior to 2012, specialists whose practices emphasize examination and management of patients occupied nine seats.\(^\text{19}\) In 2012, the RUC added a permanent seat for a geriatric specialist and a permanent rotating seat for an actively practicing primary care physician.\(^\text{20}\)

---


\(^{18}\) To calculate payment for each physician service, the components of the fee schedule (work, PE and MP RVUs) are adjusted by geographic practice cost indices (GPCIs). The GPCI is intended to reflect the relative costs of physician work, PE and MP in a geographic area relative to the national average costs for each component. RVUs are converted to a dollar amount by a CF and a schedule of dollar amounts for each physician service. The CF is calculated by CMS’ Office of the Actuary. The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule locality is:

\[
\text{Payment} = \left[ (\text{RVU work} \times \text{GPCI work}) + (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU malpractice} \times \text{GPCI malpractice}) \right] \times \text{CF.}
\]

\(^{19}\) National Commission on Physician Payment Reform, *supra* note 12, at 19.

Criticisms of the RBRVS and RUC

CMS is required by Section 1848(c)(2)(B)(i) of the Social Security Act to review all RVUs at least every five years. Since 1996, CMS has conducted four such five-year reviews of work RVUs, two five-year reviews of the PLI RVUs, and one five-year review of PE RVUs, which preceded a four-year transition to a new “bottom-up” methodology for determination of resource-based PE RVUs. Nevertheless, the RBRVS has been criticized as yielding RVUs founded upon data sources that provide anecdotal, subjective, and unreliable data. For example, it has been argued that the work RVUs overestimate the time required to perform each physician service, due to the tendency of the RVU-review process to lag behind the decline in prices for medical equipment and supplies with the development and improved availability of new technologies. It has also been suggested that, because the time estimates derive from responses to surveys of medical specialty societies whose members have a financial stake in the survey results, the time estimates are subject to bias.

Other observations have focused on the PE RVUs, which are claimed to lack foundation in objective data. For example, MedPAC has questioned the accuracy and CMS’ reliance on survey responses, from clinical employees who work in practitioners’ offices, for each physician specialty, regarding prices for equipment and supplies and total practice costs.

---

25 Id..
26 Id.
With regard to the RUC, commentators have remarked that the composition of the RUC’s panel is dominated by specialists who perform surgical and other highly technical procedures. It is argued that the RUC’s panel members have a financial stake in the valuation of procedures that either they or their colleagues perform. This bias in the RUC’s composition, some contend, has produced an RVU-valuation process skewed toward surgical and technical procedures and the relative under-valuation of services performed by practitioners whose services are more “cognitive” in nature, e.g., emergency medicine, internal medicine, family medicine, geriatrics, neurology, pediatrics, psychiatry, and rheumatology.\(^{27}\) Consequently, it is observed, the MPFS contains built-in disincentives to spend time with patients with chronic conditions, and more time on highly reimbursed procedures. Critics thus contend that the panel’s composition is at least partly responsible for inflated valuations of surgical and other technical procedures and the undervaluation of evaluation and management services, such as care coordination, prevention of chronic disease, and wellness services.\(^{28}\)

In addition, the panel has come under fire for the lack of transparency in its operations, including the panel’s non-public meetings, non-disclosure of individual votes on panel recommendations, and the confidentiality agreements required of the RUC’s members.\(^{29}\) Another challenge to the RUC contends that CMS’ 90% historical adoption rate of the RUC’s recommendations demonstrates that the RUC in fact constitutes a de facto federal advisory committee. As such, goes this argument, the RUC’s operations should comply with the sunshine and oversight requirements of the Federal Advisory Committee Act.\(^{30}\)

Defenders of the RUC maintain that, although RUC members are nominated by their specialty societies, they are precluded from commenting when codes within their specialty are presented for valuation.\(^{31}\) With regard to the assertion that the RUC

---


\(^{28}\) Fiegel, supra note 20; National Commission on Physician Payment Reform, supra note 12, at 15.

\(^{29}\) National Commission on Physician Payment Reform, supra note 12, at 19; Ginsburg, supra note 12; Reinhardt, supra note 23.

\(^{30}\) National Commission on Physician Payment Reform, supra note 12, at 19; Reinhardt, supra note 23. The Federal Advisory Committee Act is codified at 5 U.S.C. App. 2.

\(^{31}\) Williams, supra note 17.
constitutes a de facto federal advisory body, a federal appeals court in January 2013 affirmed the dismissal of a lawsuit that alleged CMS’ reliance on the RUC violated the Federal Advisory Committee Act.\(^{32}\)

*Efforts to Reform the RVU Update Process*

Enumerated below are some of the efforts to remedy the weaknesses identified in the RVU valuation process and to address some of the RUC’s operational issues:

- The Deficit Reduction Act of 2005\(^{33}\) reduced payment for the technical component of some imaging procedures by reducing the payment for producing the image when multiple images were taken at one session. It capped the payment for imaging services according to rates paid by Medicare in the locality under the Hospital Outpatient Prospective Payment System.

- In 2007, following a mandatory five-year review of billing codes, the RUC recommended, and CMS accepted and implemented, an increase in the relative value of evaluation and management services, based on the proposition that delivering evaluation and management services to an aging population now requires more time than it formerly did.

- CMS replaced the patchwork of surveys with a national survey conducted by AMA for the 2010 RBVS.

- Beginning in CY 2009\(^{34}\) CMS and the RUC have identified and reviewed potentially misvalued codes on an annual basis. CMS has indicated that it used objective data, such as operating room logs, to address some misvalued codes.

- The Patient Protection and Affordable Care Act of 2010 (ACA)\(^{35}\) supplemented the “misvalued codes” initiative by requiring the U.S. Department of Health and Human

---


\(^{34}\) 77 Fed. Reg. 68892, 68896.
Services to periodically identify, review, and adjust relative values for potentially misvalued service codes based on several identification screens.36

- As noted above with regard to the RUC, permanent seats for a geriatric specialist and an actively practicing primary care physician were added to the RUC’s panel, thus increasing the representation of specialties with emphasis on evaluation and management services.37

These efforts to reform the RVU-valuation process and address some of the operational issues with the RUC reflect a consensus that the RBRVS must incorporate more accurate measures of the relative costs incurred by practitioners to perform physician services if we are to improve the validity of the payment rates ultimately set forth in the MPFS.

**ACA Tweaks of the Medicare Physician Fee Schedule—The Non-Disappearance of FFS**

Beyond improvements in the RBRVS, many initiatives have been undertaken to achieve broader Medicare physician payment reform. Some of these efforts center on incorporating metrics or other mechanisms into FFS payments made under the MPFS, which are intended to take into account quality and value (cost). The ACA features an array of refinements to the MPFS that are intended to incentivize efforts to improve the quality and efficiency of healthcare services, including the following:

---

36 Section 3134 of the ACA amended Section 1848(c)(2) of the Social Security Act, by adding a new statutory provision which requires HHS to review potentially misvalued services, 42 U.S.C. § 42 U.S.C. 1395w–4(c)(2)(K). Misvalued services are to be identified by examining relative values pursuant to the following criteria: (1) billing codes and families of codes for which there has been the fastest growth in volume; (2) codes or families of codes that have experienced substantial changes in PEs; (3) recently established codes that are recently established for new technologies or services; (4) multiple codes that are frequently billed in conjunction with furnishing a single service; (5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; (6) codes which have not been subject to review since the implementation of the physician fee schedule; and (7) other codes determined to be appropriate by the Secretary.
• The value-based payment modifier to the MPFS. The modifier increases or decreases payment to each physician based on CMS’ assessment of value, which is to be determined by indicators of quality and efficiency (i.e., costs).\textsuperscript{38}

• The Medicare Shared Savings Program and authorization of ACOs.\textsuperscript{39} This program retains FFS payment for services rendered by physician participants in the ACO, but provides physicians with potential rewards and penalties, with the objective of making them accountable for the quality and efficiency of care furnished to FFS beneficiaries. Risk of losses provides accountability and is intended to stimulate coordination of care and referrals to specialists who are perceived as providing high-value services;

• Testing of patient-centered medical homes.\textsuperscript{40} Some of these projects retain FFS payments and simply pay higher rates for physicians practicing in a medical home, while others add payments for specific items that are not currently paid for by Medicare, e.g., telephone calls, email, care coordination, patient education, and counseling. The additional payment theoretically frees the physician or advanced-practice nurse to delegate tasks to others, which may also expand availability of primary care and mitigate shortage; and

• Specification of a higher-presumed utilization rate of advanced imaging equipment in imaging services, which enhance productivity and supposedly reduce PE RVUs.\textsuperscript{41}

Enormous effort underlies the development and implementation of these various “tweaks” of the FFS payments set forth in the MPFS and determined by the RBRVS methodology. They may indeed incentivize improvements in quality and efficiency. As long as FFS remains key to the structure of the MPFS, time will tell whether the MPFS remains subject to the historic tendency of FFS payments to stimulate service volume.

\textsuperscript{38} Section 3007 of the ACA authorized the new value-based payment modifier by adding a new statutory provision to Section 1848 of the Social Security Act, 42 U.S.C. § 1395w-4(p).

\textsuperscript{39} Section 3022 of the ACA established The Medicare Shared Savings Program, pursuant to Section 1899 of the Social Security Act, 42 U.S.C. § 1395jjj.

\textsuperscript{40} Section 3502 of the ACA.

\textsuperscript{41} Section 3135 of the ACA modified the presumed equipment utilization factor in an amendment to Section 1848 of the Social Security Act, 42 U.S.C. § 1395w-4(b)(4)(C).
and growth in expenditures, or if bonus payments that take costs into account will move the needle with regard to total physician expenditures.

Incentives for the Improvement of Access to Primary Care Services

Quite apart from efforts to reform the RBRVS and incorporate metrics and modifiers capturing the quality of the physician services actually delivered to Medicare beneficiaries, initiatives are underway to improve access to physician services, particularly primary care services.

The ACA established two such programs. Beginning in 2011 and continuing through 2015, the Primary Care Incentive Payment Program (PCIP) will provide primary care practitioners with incentive payments equal to 10% of the Medicare payment for primary care services. The incentive payments apply to primary care services with Current Procedural Terminology codes 99201 through 99215 and 99304 through 99350, and the payments are made on a quarterly basis. To be eligible for the incentive payment, a primary care practitioner must have a Medicare specialty designation of family medicine, geriatric medicine, pediatric medicine, internal medicine, nurse practitioner, clinical nurse specialist, or physician assistant, and primary care services must have accounted for 60% of the practitioner’s total allowed charges under the MPFS in the CY that is two years prior to the PCIP incentive payment year.42

In 2011, CMS’ Center for Medicare & Medicaid Innovation announced the Comprehensive Primary Care Initiative (CPC Initiative), a four-year, multi-payer initiative in which CMS pays selected primary care practices in seven geographic markets, in addition to FFS payments, a risk-adjusted, monthly care management fee, which CMS initially set at an average of $20 per beneficiary per month. The care management fee is intended to support enhanced, coordinated services for Medicare FFS beneficiaries. Simultaneously, participating commercial, state, and other federal insurance plans are offering enhanced payment to primary care practices designed to support the availability

42 Section 5501(a) of the ACA authorized the PCIP’s quarterly incentive payment program by amending Section 1833 of the Social Security Act, 42 U.S.C. § 1395l(x).
of high-quality primary care to plan members. Selected practices may also receive shared savings payments in the last two years of the initiative.\textsuperscript{43}

CMS has described the CPC Initiative’s premise as follows:

Without a significant enough investment across multiple payers, independent health plans—covering only their own members and offering support only for their segment of the total practice population—cannot provide enough resources to transform entire primary care practices and make expanded services available to all patients served by those practices.\textsuperscript{44}

Participating providers began delivering enhanced primary services under the CPC Initiative in 2012. According to CMS, 497 primary care practices currently provide enhanced primary services under the CPC Initiative, which represents 2,347 providers in seven markets across the country, serving approximately 315,000 Medicare beneficiaries.

\textbf{Conclusion}

At least one analyst has suggested that programs such as PCIP and the CPC Initiative that provide bonus and other incentive payments for primary care services plainly demonstrate congressional lack of confidence that the changes in relative values targeted by the various reforms of the RBRVS would produce increased Medicare payment for primary care services.\textsuperscript{45} In any event, whether or not the SGR is permanently repealed this year or at some other time in the near future, it seems fair to say that we are on a road to multi-faceted changes in Medicare physician payment, although it is not at all clear now how long it will take to reach our ultimate destination,

\textsuperscript{43} Section 3021 of the ACA added Section 1115A to the Social Security Act, 42 U.S.C. § 1315a, which established the Center for Medicare and Medicaid Innovation within CMS. The Center for Medicare and Medicaid Innovation launched the Comprehensive Primary Care Initiative under this authority. See also CMS, “Fact Sheet: Comprehensive Primary Care Initiative,” available at http://innovation.cms.gov/Files/fact-sheet/CPCI-Fact-Sheet.pdf (last accessed Mar. 31, 2013) (hereinafter, Fact Sheet).

\textsuperscript{44} CMS Fact Sheet, \textit{supra} note 45.

\textsuperscript{45} Ginsburg, \textit{supra} note 12, at 1980.
how many interim destinations we might visit along the way, or how rocky the road might prove to be.

*Christine Covert Cohn, JD, MSPH (Law Office of Christine Covert Cohn, Encino, CA).