Statement before the House Committee on Budget

Center for Medicare and Medicaid Innovation

Scoring Assumptions and Real-World Implications

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Mr. Chairman, Ranking Member, and members of the Committee, thank you for the opportunity to participate in today's hearing, Center for Medicare and Medicaid Innovation (CMMI): Scoring Assumptions and Real-World Implications.

I am the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), a nonprofit, nonpartisan public policy research organization based in Washington, DC. I was formerly the Assistant Director for Health and Human Resources at the Congressional Budget Office (CBO), and subsequently a member of CBO's Panel of Health Advisers for seven years. Earlier I was Director of the Office of Research and Demonstrations in the Health Care Financing Administration—the counterpart to CMMI in the Centers for Medicare and Medicaid Services (CMS).

Today's hearing raises concerns about the ability of CBO to estimate the budget impact of CMMI's demonstration projects. Because of the scoring conventions and assumptions used by CBO, attempts by Congress to modify CMMI demonstration projects typically are assumed to increase federal cost. That has inhibited legislative action to make adjustments deemed by many Members to be necessary.

The most important issue is CBO's decision to account for savings that might be lost for "initiatives CMMI is undertaking (*or is expected to undertake*)" [emphasis added] in assessing legislative proposals.[1] This remarkable decision to score lost savings for demonstration projects that have yet to be announced is a sharp break with past practice. Just as CBO does not score legislative proposals that have not yet been advanced, it seems unreasonable for them to score actions by CMMI that have not yet been advanced.

While CBO's assumptions are a serious concern, they are not the source of the problem. The situation Congress finds itself in arises because the Affordable Care Act (ACA) made an unprecedented transfer of power to the executive branch. Congress can act to resolve this, but that will require agreement on legislation that would be difficult to achieve.

Given my experience, I agree that demonstration projects can be a useful tool in testing alternative policies that could improve health care delivery and slow cost growth. I also strongly support CBO's role in providing budgetary analysis to inform Congress as it considers new legislation. But I am acutely aware of the limitations that research and budget analysis have in projecting the future impact of new approaches on the health system and health spending.

Shift of Authority to CMMI

The Affordable Care Act created the Center for Medicare and Medicaid Innovation to test new payment and delivery models intended to "reduce program expenditures . . . while preserving or enhancing the quality of care."[2] The ACA specifies a long list of models that could be tested in Phase I demonstration projects. Models that are judged by CMS to be successful may be expanded in a Phase II project.

The Secretary of Health and Human Services (HHS) has the authority to expand the scope and duration of a model being tested through rulemaking rather than seeking to make program changes through legislation. A model that either reduces spending without reducing the quality of care or improves quality without increasing spending could be expanded, potentially nationwide.

CMMI has greater independence in developing and implementing demonstration projects than has been typical for regulatory actions undertaken by executive branch agencies. When a government agency issues a new regulation, it generally does so within the statutory and policy framework enacted into law by Congress. For example, CMS is currently in the process of finalizing rules to implement changes in Medicare physician payment under the Medicare Access and CHIP Reauthorization Act (MACRA), which specifies that physicians will receive a 5 percent bonus for participating in alternative payment models.

In contrast, CMMI has the authority to develop policy for the Medicare program de novo, and may test any new policy approach without specific direction from Congress. CMMI could test a model that changed the terms prescribed by MACRA, perhaps reducing the physician's bonus to 2 percent to determine how important the larger bonus specified in law is for moving physicians to alternative payment models. CMMI would not be required to use the formal notice and comment rulemaking process in making this change. This allows CMMI to roll out new proposals quickly without a formal opportunity for public comment or agency responses to such comments.

CMMI also differs from previous demonstration authorities such as those I oversaw in my time with the agency. Most of those demonstrations shared a few key features: they were time-limited, typically between three and five years; they were budget neutral; and they were voluntary. In contrast, CMMI demonstrations are not time-limited, and Phase I demonstrations need not be budget neutral. Several demonstrations—including the Comprehensive Care for Joint Replacement Model, the proposed Part B Drug Payment Model, and the proposed episode-based model for cardiac care—will require mandatory participation.

CMMI has the ability to test new payment models, including models that mandate provider participation on a wide scale, without needing to seek congressional approval. Moreover, the Secretary can expand the scope and duration of a model that the agency determines is successful. Such an expansion does not require congressional approval. That constitutes a fundamental shift from Congress to the executive branch in the ability to set policies for some of our nation's most important and costly public programs.

Challenges for CBO

The Congressional Budget Office provides estimates of the budget impact of virtually every bill approved by congressional committees as well as many informal, preliminary estimates that serve as guidance as Congress develops legislative proposals. In an analysis released in

2015, CBO estimates that “CMMI operations will reduce spending by about $27 billion, on net” over the next decade.[3]

CBO credits CMMI’s unique construct—its ability to work flexibly and quickly and to expand successful model tests—as the main source of savings. This creates a number of challenges for CBO’s ability to maintain a reliable baseline and, as a result, for Congress’ ability to legislate in areas that impact, or have the potential to impact, CMMI’s activities.

- **Uncertain Evaluation of Demonstration Projects**

Models tested in Phase I demonstrations are evaluated to determine if they are likely to reduce spending without reducing the quality of care or improve quality without increasing spending. Models that meet that test could be expanded in a Phase II test. CMS’s Chief Actuary is tasked with assessing the spending impact, and other components of CMS assess the quality impact.

What is sometimes overlooked is that any assessment of the spending impact of a CMMI demonstration project is not a simple accounting exercise. Whether provided by the CMS Actuary or by CBO, such an estimate is a projection of *future* program savings based on limited data and modeling assumptions that themselves are based on limited information. The estimate is, ideally, the best one can forecast at the moment, but the savings are far from certain.

Moreover, how one sets the baseline of spending that is assumed would have occurred in the absence of the demonstration project determines which health care organizations are willing to participate (in the case of a voluntary demonstration) and how much net savings are estimated. Small changes in assumptions can lead to significantly different conclusions about whether a project is successful or not.

The accountable care organization (ACO) demonstration is a case in point. Harvard professor Ashish Jha recently investigated CMS claims that ACOs in the Medicare Shared Savings Program (MSSP) saved over $1 billion last year.[4] For the 392 ACOs for which CMS reported results, he found that the ACOs that came in under their target level of spending saved $1.5 billion, but those coming in above the target lost $1.1 billion. By that measure, net savings were $0.4 billion for the year.

However, Jha found that the “winners” had higher benchmarks, on average. The winners spent *more* money per capita than the “losers,” but the higher benchmarks meant that CMMI calculated savings for them. It is unclear why the benchmarks were higher. Jha suggests that they may have had sicker patients, but it is also possible that some of them were higher-cost providers due to inefficiency. That cannot be easily ascertained from the data.

Did the taxpayer save money? Jha pointed out that CMS had to remit some of the net savings back to the higher-performing ACOs in the form of bonuses (“shared savings”). Moreover, because almost every ACO in the report is in a one-sided risk-sharing program,

CMS pays money out when organizations save money relative to their individual benchmark—but does not get money back from ACOs that lose money for Medicare. Consequently, the net impact was a loss of $216 million dollars in 2015.

A central question is how CMMI sets the spending benchmark for each participant in its demonstration projects. Setting the benchmark at a high level offers two advantages. First, a high benchmark is likely to be easier to beat, in terms of reducing spending. That will make the demonstration more attractive to potential participants. Second, a high benchmark is more likely to result in estimated savings, as Jha's analysis clearly demonstrates.

The assumptions used by CMMI to set an individual benchmark are subject to judgment, as is the case with every part of the budget estimation process. Those assumptions are based on information that is particular to an organization, but are inherently limited since they represent judgments by the agency about the future course of spending or forces influencing that spending. Changes in where to set a parameter in a cost model that seem reasonable can swing the benchmark higher even though there is often no good analytic basis for settling on the final parameter.

This illustrates the difficulties of determining whether a CMMI project is a success in reducing spending. Even when the CMS report seems favorable, the complexity of what seems like a simple question is daunting. Without independent analysis of hard data, there is no reason to take claims of success at face value. Even with such analysis, whether there appear to be savings or not depends on decisions made by CMMI about the benchmark or other aspects of the demonstration project that may be seriously flawed.

- **Model Overlaps Increase Uncertainty**

Another complication arises because of the profusion of demonstration projects initiated by CMMI. Former CMS Administrator Gail Wilensky recently observed that after a slow start in 2011, CMMI seems to have gone into overdrive.[5] In addition to MSSP, there are Next Generation ACOs, Comprehensive Primary Care, Comprehensive Primary Care Plus, Bundled Payment for Care Improvement (BPCI), Comprehensive Joint Replacement program, and others. Because many of these projects are being conducted at the same time with the same providers, there is a complicated interaction that can affect the savings calculated by CMMI for a specific project.

The clearest example is the overlap between the ACO model and BPCI.[6] To avoid double-counting savings (and thus having to pay out unearned bonuses), CMMI must decide which of the programs is attributed with savings. It is possible given the program rules that an ACO could lose its shared savings payment for the year if the hospital in the ACO is also participating in BPCI. In that case, hospital savings associated with BPCI are credited to the hospital, and those savings are subtracted from the ACO. That shift of savings could reduce the savings rate below the 2 percent minimum necessary for the ACO to receive shared savings.

The CMMI rule is arbitrary by necessity. There is no simple way to avoid paying excessive bonuses because of the overlap without disadvantaging some party.

This problem points to the larger issue: How do we know which of the many policy initiatives conducted by CMMI can be counted on to reliably yield budget savings? A decision by the Secretary to require a specific model based on CMMI analysis may yield disappointing results if other models that were operating simultaneously are excluded.

Other changes in the market environment when CMS moves from the demonstration phase to full policy could have an even larger impact, reducing expected savings as providers adapt to rules and payment mechanisms that have become permanent. The inherent difficulty of accurately predicting which models successfully reduce spending in the long term affects CBO's ability to maintain an accurate 10-year baseline.

- **Unspecified Future Demonstrations Included in Estimates**

CBO assumes that CMMI operations will yield net budget savings that grow in the future. They base this assumption on the flexibility and authority granted CMMI by the ACA. However, 10-year cost estimates depend on assumptions made by CBO about ongoing demonstration projects, whose operations could be changed by CMMI in its attempt to improve results. They also require CBO to make assumptions about the budget impact of projects that have not yet been released publicly, and whose details may not be known for years.

The ACA has given CMMI permanent funding of $10 billion every decade for demonstration projects, which increases both the number of projects and their scope.[7] CBO seems to believe that increasing the pace of demonstration activity ensures the development of policies that yield net budget savings. Experience suggests that this is optimistic. Gail Wilensky observed that pilot projects can be useful, but they seem to be better at showing which strategies do not work rather than which ones do.[8]

CBO also argues that the broad authority given the Secretary to modify, halt, or implement as policy the models being tested in the demonstration projects will result in net budget savings. That assumes CMS's judgment about which models are working and which are not will generally be correct.

But as suggested earlier, the cost assessments performed by the Actuary have the same flaws as other economic projections. Actuaries and economists extrapolate, albeit in complex ways, past trends. Those extrapolations may be poor predictions of the spending that will actually occur, particularly if new demonstration projects that had not been taken into account are introduced later.

An example of CBO's legislative scoring that made assumptions about a CMMI demonstration project that had not been announced is H.R. 2581, the Preservation of Access for Seniors in Medicare Advantage Act of 2015. CBO's estimate, released on June 15, 2015, states that the Value-Based Insurance Design (VBID) Demonstration Program

proposed by the Act would increase Medicare spending by $210 over 10 years.[9] CBO based this on its expectation that "CMMI will conduct a demonstration program under current law that is substantially similar to the program proposed under the legislation."

While it was reasonable to assume that CMMI would test VBID at some point, there was no announcement of such a test until September 1, 2015, when a memorandum was sent to Medicare Advantage organizations.[10] The memorandum stated that the model test was scheduled by CMMI to begin on January 1, 2017, and would be conducted in 7 states on a voluntary basis.

This example raises a serious concern. CBO estimated savings for a demonstration project that had not yet been announced by CMMI. CBO has a long-standing policy of releasing formal estimates only after a proposal has been marked up. The scores are based on legislative language, rather than general specifications. But in the case of CMMI projects, CBO apparently is content to provide scores based on informal discussions and information that is not available publicly.

CBO's scoring approach is the consequence of the ACA's shift of authority from Congress to the executive branch. Consider an alternative scenario, in which every demonstration project must be legislated by Congress—that is, CMMI would not exist. CBO would score each proposal on its merits in the context of CMS program operations as they are at that time and likely to be in the future. No consideration would be given to legislative proposals that have not been advanced, and generally none would be given to proposals that have been advanced but not enacted unless they were part of the same bill.

Under that alternative, Congress would generally be faced with fairly modest budget costs if it passed a subsequent bill that modified a previously legislated demonstration project. In contrast, at the present time CBO estimates significant costs for congressional proposals to alter CMMI projects based on the assumption of savings from projects that may not be implemented, or even announced, for years to come.

Options for Congress

The Affordable Care Act gave extraordinary power to CMS to change the way health care providers are paid and the way services are delivered. CMMI is the vehicle through which a multitude of new models are being tested, and the HHS Secretary has the authority to implement any model that is certified to reduce program spending or improve quality without going through Congress. The move by CMMI to demonstration projects that mandate participation by providers results in changing policy, at least for those providers. A decision by the Secretary to require nationwide implementation of a specific model that was tested in a demonstration project would be a de facto change in law without the inconvenience of congressional debate.

Congress has several options to address this shift in power, but any change in the current situation is likely to be difficult. Legislation could make adjustments to individual demonstration projects as issues arise. Alternatively, Congress could repeal CMMI as it now

stands. In its place, CMS would perform research into new payment and delivery models without the authority to require participation by providers or the power to unilaterally impose new models on the health sector.

CBO would score such proposals as increasing the deficit. That does not mean Congress could not find a savings offset. It also does not mean that Congress must find an offset to enact legislation. The issue in this case is not the deficit, but the separation of powers between the executive and Congress. No President would voluntarily return the authority given by the ACA. If Congress wants that authority back, it will have to act.

Notes

[1] Paul Masi and Tom Bradley, "Estimating the Budgetary Effects of Legislation Involving the Center for Medicare & Medicaid Innovation," Congressional Budget Office, July 30, 2015, https://www.cbo.gov/publication/50692.

[2] Section 1115A of the Social Security Act (as added by section 3021 of the ACA).

[3] Masi and Bradley, op. cit.

[4] Ashish Jha, "ACO Winners and Losers: A Quick Take," An Ounce of Evidence, August 30, 2016, https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take/.

[5] Gail Wilensky, "Time to Hit the Pause Button on Medicare's Payment Demonstration Projects?" JAMA Forum, August 31, 2016, https://newsatjama.jama.com/2016/08/31/jama-forum-time-to-hit-the-pause-button-on-medicares-payment-demonstration-projects/.

[6] Jon Pearce, "The Strange Financial Interactions Between Medicare ACOs and Bundled Payment Participants," Singletrack Analytics, November 5, 2013, http://www.singletrackanalytics.com/blog/13-11-05/strange-financial-interactions-between-medicare-acos-and-bundled-payment-participants; and Robert E. Mechanic, "When New Medicare Payment Systems Collide," *New England Journal of Medicine*, May 5, 2016, http://www.nejm.org/doi/full/10.1056/NEJMp1601464.

[7] Masi and Bradley, op. cit.

[8] Wilensky, op. cit.

[9] CBO, "H.R. 2581, the Preservation of Access for Seniors in Medicare Advantage Act of 2015," June 15, 2015, https://www.cbo.gov/publication/50307.

[10] CMMI, "Announcement of Medicare Advantage Value-Based Insurance Design Model Test," September 1, 2015, https://innovation.cms.gov/files/x/mavbid-announcement.pdf.