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Assignment: The **transition** of short term to long range projections

- How do APMs/ACOs/other value-based payments affect Medicare cost estimates/projections? What is impact? Is it generalizable? Is it level shifting versus bending the curve?

- **Define the issue or assumption being discussed**

  There are many changes underway within CMS and the healthcare environment—CMS, providers, carriers are all developing programs, making decisions, and taking action with potentially multi-year impacts. This material focuses on a subset of these changes, provider-based programs which also make some changes in the payment system. Responsible providers with aligned payments and the right support have the potential to create better care, smarter spending, and healthier populations. These types of changes could impact the short and long term forecasts.

  Based on their source and stage of implementation, there are several categories of changes in provider payment and organization that could affect Medicare payments.

  1. *CMS initiatives that have already been implemented.* Examples include the productivity adjustment for payments to non-physician providers and Accountable Care Organizations (ACOs). Many of these are early versions and will be changed by the transition period.

  2. *CMS initiatives which are defined in legislation but for which final rules have not been passed (or have recently been passed but have not been implemented).* Examples include the MIPS and APM programs under MACRA.

  3. *CMS initiatives for which there is a legislative path but specific rules have not been defined and implementation is uncertain.* Examples include the activities of the CMS Innovation Center.

  4. *Spillovers from Medicare Advantage.* See other memo.

  5. *Effect of private sector initiatives, either payer- or provider-driven, on public programs.* Private insurers, self-insured employers or providers themselves could drive delivery system changes, independent of Medicare reforms, that would impact the delivery of Medicare-financed services.

The issue for the Technical Panel is to determine whether and how to address the implementation or potential implementation of these types of programs into the short, transition and long run projections.

- **Why is it potentially relevant and material to the Medicare Trustees Report?**

  The Report forecasts the long-term financial status of Medicare and reflects the performance of the health industry. These types of programs could have a major impact on the industry as they impact provider behavior and the health system. Thus understanding their short and long-term impacts is important for portraying the financial status of the Medicare program as accurately as possible.

- **How is it currently reflected in the Medicare Trustees Report? (and what are the mechanisms for accounting for potential effects of delivery system changes on spending?)**

  The effects of changes in provider payment methods could impact both the short and long-run projections.

  - Short term projections: The general approach to generating short term projections is to establish a base of the cost of services provided to beneficiaries by category for the most recent year of available data and then to forecast the annual percent change in expenditures for each year in the future. The annual growth rate is determined in part by historical data and then adjusted for anticipated changes in spending growth.

    Thus, the effects of new payment models are potentially reflected through the calculation of the base and the assumptions regarding short-term growth rates. To the extent that new payment models have been implemented and have already affected Medicare spending (e.g., any effect that ACOs have already had on Medicare spending), they will generate a downward shift in the projection through their effect on the base and a "bending of the curve" to the extent that their effect on historical growth rates influence assumed future growth rates. For Part A services, the effect of new payment models could be incorporated through assumptions regarding changes in utilization and case mix and, for Part B services, new payment models could affect Medicare payments through adjustments to the volume and intensity growth assumption. Any effects of delivery system changes in the short-term projection affect the long-term forecast through their effect on the 26-year base for the long term projection, which is a linear extrapolation based on the level and rate of growth of spending at the end of the short-term projection.

    The short-term projection does not explicitly account for recent changes in the delivery system beyond those that have already affected recent historical spending.

- Long-term projections: The long-term forecast is based on the "factors contributing to growth" model. The factors model is estimated based on historical data and generates coefficients for the effects of income, coinsurance, and medical prices on growth in per capita spending. Estimation of the model also generates a residual, "volume and intensity," which serves as a baseline rate of growth. The trustees then set an annual assumption for each parameter in the model and use the model to forecast long term spending levels by category (although the categories are more aggregated than those used in the short term forecast).

  While "excess cost growth" (the difference in between growth in age-gender adjusted per capita health spending and growth in per capita GDP) is forecasted to decline over the long run, the decline is not explicitly driven by adjustments in volume and intensity due to delivery system changes. Excess cost growth is forecast to decline from about 0.85% in 2040 to about 0.5% in 2090. This is a significant reduction from the historical average which averaged 1.2% from 1990-2004.[1] This reduction is driven primarily by the income-technology elasticity.

  Thus, the key parameter for accounting for the effects of new payment models on long run spending, above and beyond those incorporated in the income-technology elasticity, is the "volume and intensity" parameter.

- **To your knowledge, has this issue been considered by prior Medicare Technical Panels?**

  Prior Medicare Technical Panels have considered and made recommendations on these assumptions. The most recent panel met after the ACA but before MACRA was passed and before many of the specific provisions regarding value-based payment driven by the ACA were defined and implemented. The current situation is different. There are more programs, some programs have been more explicitly defined, and there appears to be more activity on the part of providers. Based on the situation at the time, the panel had one recommendation focused on the effects of the ACA on volume and intensity:

  > *Recommendation III-3: The Panel recommends that the Trustees incorporate an assumption that the Affordable Care Act (ACA) will have a small, negative impact on the long-range growth rate of volume and intensity of services per beneficiary.* (Executive Summary from the 2010–2011 Technical Review Panel).

  In response to this recommendation, the trustees reduced the assumed rate of volume and intensity growth by 0.1 percent per year relative to the estimate from the factors model (2016, Medicare Trustees Report, page 168). Based on the corresponding text, this assumption appears to be driven by the actions providers may take in response to

[1] Steve Heffler, presentation to the Technical Review Panel on August 30, 2016, slide 6.

the productivity adjustment to payment rates as well as some other elements of ACA payment reform.

> *The Trustees' assumption is also based on Recommendation III-2 of the 2010-2011 Medicare Technical Review Panel, which concluded that there would likely be a small net negative impact on volume and intensity growth due to reduced incentives to develop new technologies, provider exits, and the impact of greater bundling of services for payment purposes.* (2016, Medicare Trustees Report, page 168)

Thus, the question for the current Technical Panel is whether the adjustment to the forecast made by the prior panel accurately reflects the likely long-term impact of the delivery system changes that are taking place today and in the future.

- **What are the potential alternatives to be considered and potential advantages and disadvantages of each.**

  The potential alternatives are as follows:

  - Whether to adjust the growth rate assumptions underlying the forecasts for the potential effects of the types of delivery system reforms discussed above;
  - If the committee decides to recommend adjustments:
    - Should assumptions of the short or long run forecast be adjusted?
    - Which category of spending within each forecast?
    - By how much? Various areas for investigation are listed in Appendix A.
  - Whether to recommend changes in the methodology of the short term forecast that would facilitate more accurate forecasts in the face of the development of alternative payment models, illness-based management, and provider-specific initiatives. For example, while the model treats Parts A, B and D separately, greater bundling of services into a single payment could generate overlap between programs Parts that the current methodology may not capture.

  The advantages of making adjustments is that the forecast could be more accurate. Adjustments, however, should be carefully considered. Significant deviations from prior forecasts and historical trends would send a strong signal about the trustees' expectations. Thus, adjustments should be backed by either solid evidence or be consistent with the expectations of experts to ensure the credibility of the forecast.

- **What studies or research exists that could be used to support one or more of these alternatives (cite, link or attach source)**

  - Given the rapid changes in the health care industry, a relatively deep evidence review would help to guide analysis of the potential alternatives.

- Core questions for research

    - *What is the potential impact of a type of payment or delivery system change?*
      Notes: Various sources indicate improvements are possible. Various pilots and ongoing programs show that some providers in some markets have improved performance to meet the Medicare goals of "better care, smarter spending, and healthier members." Some are achieving better care, in part because of strong resources and explicit requirements for about "better care." Progress has been uneven on "smarter spending" CMS/CMMI will be managing this over time. There are many opportunities, but also many obstacles.
    - *Is evidence from this setting generalizable?*
      Notes: There are different definition of generalizable in healthcare. For someone investigating "better care," they expect a program that has worked on an identifiable set of patients almost all the time. Someone with a management perspective working on "smarter spending" may look for an initiative that has worked well in a few locations, but not in others. They then investigate how to implement and expand the number of locations. So, the concept of ACOs or bundles is not generalizable from the first perspective; it doesn't work automatically. But, many of these programs and their underlying initiatives are generalizable from a management perspective. There are specific tasks, initiatives, experts, and organizations that make a difference.
    - *Do any reductions in spending reflect level shifting versus bending the cost curve?*
      Notes: the impact discussion above outlines the level shift. There does not appear to be consensus on the whether the ongoing changes will bend the long term cost curve for buyers. However, some providers are discussing a fundamental change in business strategy to reduce their own spending on an ongoing basis. This could have a long term impact.

- The literature review could focus on the following topics:

    - The effects of recent payment reforms implemented by Medicare on Medicare spending (e.g. ACOs including studies by CMS and McWilliams, Chernew et al.). Review should differentiate between the stronger and typical performers and the committee should consider the assumption that program will reflect stronger performers over time
    - The effects of value-based purchasing in either other public or private programs.
    - Any evidence of spillovers from private sector initiatives to Medicare spending?

- Investigations could include the following sources:

    - Leading experts (with historical expertise on similar programs)
    - Published literature and grey literature
    - Information within CMS (internal analysis, provider bids, analysis of stronger programs, provider variation, etc.)
    - Financial impact of upcoming developments (such as physician bonus methodology)
    - Analysis by Illness (to be extended over time)

  The industry and CMS is changing very rapidly. This requires supplemental and non-traditional sources of information can keep up with the pace of change. See appendix B.

- **Are there speakers we should entertain to inform our consideration of this issue/assumption?**

    - There are many possible topics. Each topic has its own set of experts. Once the panel determines its interests, specific resources and speakers are available.

    - Speakers could include, researchers, medical directors with practical experience, experts on each program, experts in provider-based management across multiple programs, experts on financial performance and smarter spending (such as physician incentive compensation, hospital expenditure management, etc.)

    - An overview from CMS to discuss about the implementation of MACRA including the details of the payment changes, bonus payments, and any forecasts done to support these changes.

Appendix A—Areas for potential investigation (program specific)

Each program has its own characteristics and possible implications. These programs also have some overlap. As an example of issues with medium and long term implications:

1. How do hospital-based ACOs perform differently from physician-based programs? Some of the early top ACO performers have been physician-based. How is the mix expected to change over time?
2. Some providers discuss ACO as a transition approach to other options—what is the implication.
3. Various programs will change and improve over time under existing law. For example, ACO_{2027} will be different and stronger than ACO_{2017}, etc.
4. Will the various MIPS/APM bonuses have a major impact on care, spending, consolidation, and other issues? What happens when some elements expire?
5. If a critical mass is needed to achieve change, do the changes in MA and ACO reinforce each other?
6. Individual incentives are needed for physicians. Will the physician incentives encourage smarter spending? What MIPS and APM metrics will be used?
7. Some private sector programs see a sentinel effect of physician-level bonuses (providers who are monitored have less incentive to overuse services
8. Bundled currently apply to only some illnesses. How far can this expand over time?
    a. How do programs overlap?
    b. CMS has a wide presence in the market, but also works within the Medicare structure and requirements in the law. How does this impact the program?
9. How much impact will a continuing growth of Part D have on other expenses? Is there variation now between markets with high and low Part D penetration?

Appendix A—Areas for potential investigation (overall)

1. What is the state of these programs at the transition from short to long term. Are there major changes near the end of the period?
2. Track the provider move to "smarter provider spending." How many markets and provider executives are committed "smart provider spending."
3. Smart provider spending sometimes impacts claims, sometimes it does not. How much of this is passed along to CMS?
4. Cumulative effect of changes in intensity score at the end of the transition period?
5. Discuss investigations and analytic approaches that might be developed in the near future to monitor and/or manage the developing state of the industry (to support the next panel focused on these topics).
6. Develop deeper analytic techniques around spending by illness.
7. Information on initiatives to "better care" and healthier people are relatively easy to find. Information on initiatives to create smarter spending is not readily available to providers or CMS. We may want to identify potentially useful initiatives.
8. Given consolidations, MA, ACO, etc., decisions and actions are frequently coming from organizations rather than individual providers. It would be useful to understand provider decision making.

Appendix B—Supplemental and non-traditional analysis

In a rapidly changing environment, many non-traditional approaches can be very useful. This information must be used cautiously, but there are ways to obtain useful insights into the direction of the industry as well as identify specific actions which should be spread more widely.

For example:

1) Analysis of the future can start with a review existing strong programs and/or the underlying initiatives (from early adopters or growing existing organizations).
2) Provider assessment
3) Gap analysis (magnitudes)
    i) Strong and weak performers
    ii) By location
    iii) By illness
    iv) Impact of implementation (weak and strong)
4) Obstacles and how to overcome them
5) Leading indicators (project impact before it hits claims)