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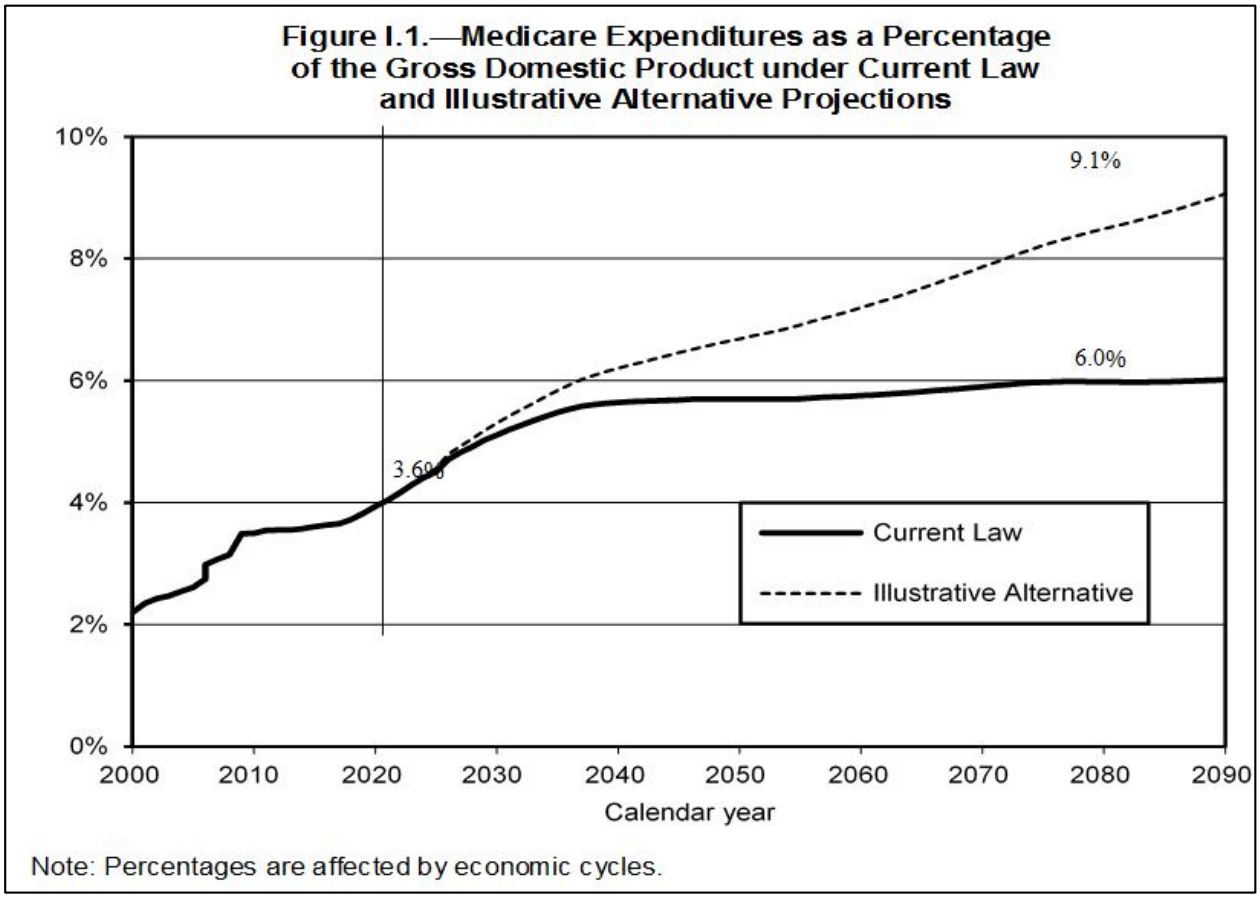
Assignment: Long-term rate of growth, the sustainability of key Medicare cost growth factors under current law, focusing on the role of alternative projection post-SGR

Define the issue or assumption being discussed

The Trustees report presents projections under current law as well as an "illustrative alternative" to current law. The "current law" projection incorporates the effect of MACRA on physician payment levels and ACA-mandated reductions, primarily the "multifactor productivity" adjustments to payments to hospitals and other providers, but "not the payment reductions and/or delays that would result from the HI trust fund depletion." The alternative projection deviates from current law by assuming that certain spending-reducing provisions will not occur as stipulated in law. The following figure summarizes the projections under current law and the illustrative alternative:

Figure 1



The issue under discussion is whether the alternative scenario should continue to be included as part of the report, and if so, whether the modeling is based on appropriate assumptions and the language in the report accurately describes the relevant sustainability issue.

The specific questions identified by the Office of the Actuary are:[1]

- *What additional analysis should support the sustainability issues?*
- *Does the language used in the overview adequately describe the future uncertainty for the Medicare program associated with the sustainability issues?*
- *Is there value in producing an alternative to current law?*
- *If so, what are the appropriate assumptions to support the alternative scenario?*

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

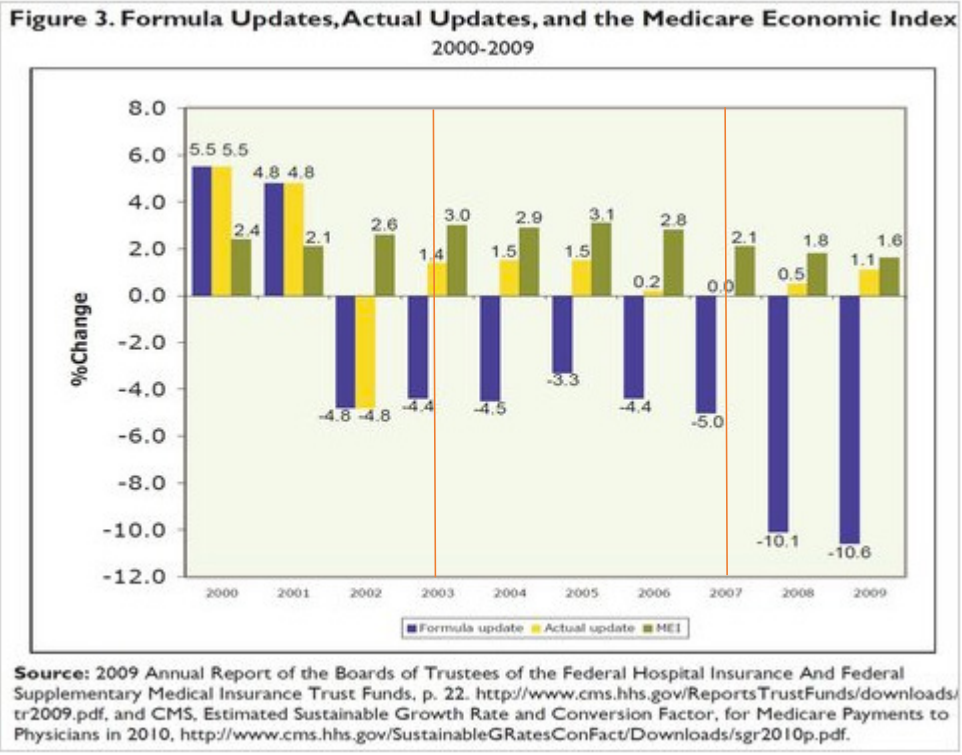
The alternative scenario demonstrates the implications for the trust fund if the provisions of the ACA and subsequent legislation that impact Medicare payment rates are scaled back. Based on historical precedent, the potential for provider payment cuts to be overturned is very real. The SGR, a statutory method for determining the annual update to the Medicare physician fee schedule, was established as part of the Balanced Budget Act of 1997. Under the SGR formula, the update for provider payment rates in a given year depended on the level of Medicare spending for physician services in the prior year relative to a target. If spending exceeded the target, then future updates were reduced to bring spending back in line with the target. Medicare payments to physicians were reduced by the SGR formula for the first time in 2002. In 2003 and each subsequent year, however, Congress passed legislation overriding the payment reduction.[2] The figure below compares the SGR legislated to the implemented payment changes each year.[3]

[1] Heffler, "Medicare Lon-Run Current-Law Sustainability Issues," Office of the Actuary. Presentation to the Technical Review Panel on the Medicare Trustees Reports, August 30, 2016.

[2] According to the Committee for a Responsible Federal Budget, the "doc fixes' were offset by savings in other programs, many of them health care related, 98% of the time. See http://theincidentaleconomist.com/wordpress/how-congresss-doc-fixes-have-been-mostly-fiscally-responsible/

[3] Source of picture: http://economix.blogs.nytimes.com/2010/12/17/the-annual-drama-of-the-doc-fix/ which references a CRS report by Jim Hahn, "Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System, November 6, 2009.

Figure 2



Source: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, p. 22. http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf, and CMS, Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010, http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf.

The first reference to the illustrative scenario was in the 2007 Trustees Report which cautioned that forecasts of Part B spending under current law were likely to be underestimated due to the annual SGR override:

> *"Given recent history, multiple years of significant reductions in physician payments per service are very unlikely to occur before legislative changes intervene. Scheduled negative physician fee updates in 2003 through 2007 have already been avoided by legislation, and the negative physician fee update scheduled for 2008 is larger than any of those previously avoided. However, these unlikely payment reductions are required under the current-law payment system and are reflected in the Part B projections shown in this report. Therefore, the Part B, total SMI, and total Medicare estimates shown for 2008 and thereafter are likely understated and should be interpreted cautiously."*

The 2007 report provided an alternative estimate in a separate, publicly available report.[4] The 2010–2011 Technical Panel extensively discussed the alternative projection and ultimately recommended including it in the main report:

> ***Recommendation IV-4:*** *The Panel further recommends inclusion of the alternative projections within the Medicare Trustees Report, in the form of a chart (and related text) that compares long-range Medicare expenditures as a percent of GDP under*

[4] http://www.cms.hhs.gov/ReportsTrustFunds/05_alternativePartB.asp

(i) current law; (ii) an alternative to current law in which physician payment rates are not as constrained as required by the SGR formula; and (iii) an alternative with both an SGR modification as above and assumed payment rate increases for other providers that are not as constrained as required by the productivity adjustments.

The alternative scenario was part of the main report for the first time in 2012 and it included these two scenarios. IPAB spending constraints were also relaxed in the alternative. In the 2015 report, after the passage of MACRA, there was only one alternative which included phasing out the productivity adjustments, repealing IPAB and phasing out MACRA. See Appendix 1 for a comparison of the illustrative alternative projections from 2012–2015.

How is it currently reflected in the Report?

The alternative scenario makes adjustments to current law in three ways: "(i) the reductions in payment updates by the increase in economy-side productivity for most non-physician provider categories, (ii) the physician payment updates specified by MACRA for all future years; and (iii) the operations of the Independent Payment Advisory Board."[5]

The main features of the alternative scenario relative to current law are as follows:

(i) Under current law, physicians would transition to MACRA payment updates of 0.75% for physicians participating in APMs and 0.25% for physicians not participating in APMs in 2026. The alternative scenario assumes that this transition would not be implemented and, instead, payment updates would transition from 0% in 2025 to 2.2% (the rate of growth in the Medicare Economic Index (MEI)) in 2040 and beyond.

(ii) Under current law (MACRA), the 5% bonuses for physician participating in alternative payment models will expire in 2025. Under the alternative scenario, they will not expire.

(iii) Under current law, it is expected that the productivity updates would decrease hospital payment rates by 1.1% per year. In the alternative scenario, the productivity adjustment will phase down to 0.4% between 2020 and 2034. In other words, the downward adjustment to payment rates to account for economy-wide increases in productivity would be limited to 0.4%

(iv) Under current law, IPAB will hold the rate of growth of Medicare expenditures to GDP plus 1%. This is binding in certain years (2019, 2024, 2026, 2028, and 2030). Under the alternative scenario, IPAB-induced reductions in the rate of growth of Medicare expenditures are not implemented.

The key sections of the Trustees Reports for understanding the technical details of these transitions are Appendix V.C and a publicly-available memo focusing on the alternative scenario.[6]

[5] 2016 Medicare Trustees Report, page 193.

[6] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2016TRAlternativeScenario.pdf

The following examples demonstrate the language used in the report to warn that payment reductions under current law may not be sustainable. For example:

> *"Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law." (page 2)*
>
> *"However, if the health sector cannot transition to more efficient models of care delivery and achieve productivity commensurate with economy-wide productivity, and if the provider reimbursement rates paid by commercial insurers continue to follow the same negotiated process used to date, then the availability and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private insurance." (page 3)*
>
> *"The financial projections shown for the Medicare program in this report reflect substantial, but very uncertain, cost savings deriving from provisions of the ACA and MACRA that lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely." (page 43)*

The memorandum identifies the purpose of the alternative projection:

> *"The purpose of the memorandum is to present a Medicare projection under a hypothetical alternative to these provisions to help illustrate and quantify the magnitude of the potential cost understatement under current law."*

The memorandum also indicates that the alternative projection should not be interpreted as a policy recommendation:

> *"At the request of the Trustees, the Office of the Actuary at CMS has prepared a set of illustrative Medicare projections under a hypothetical modification to current law. A summary of the projections under the illustrative alternative is contained in appendix V.C of this report….Readers should not infer any endorsement of the policies represented by the illustrative alternative by the Trustees, CMS, or the Office of the Actuary.*
>
> *"This analysis is for comparison purposes only and should not be interpreted or construed as advocating any particular legislative change."*
>
> *"This paper is also an attempt to promote awareness of these issues, to illustrate and quantify the amount by which the Medicare projections are potentially understated, and the help inform discussion of potential policy reactions to the situation."*

Has it been considered by prior technical panels?

At the time that the 2010 and 2011 Technical Panel was meeting, SGR was still in place (MACRA had not yet passed) and the productivity adjustments and IPAB had just been passed as part of the ACA. At that time, the panel found that both the short and long range reductions in

physician payment rates due to the SGR were highly uncertain and, as discussed above, supported the corresponding alternative projection. The Panel found that the feasibility of the productivity updates was also highly uncertain. As a result, the Panel recommended two alternative scenarios: one that assumed only SGR would be overturned and another that assumed both that SGR would continue to be overturned and that the productivity adjustments would be implemented less aggressively:

> *"The Panel further recommends inclusion of the alternative projections within the Medicare Trustees Report, in the form of a chart (and related text) that compares long range Medicare expenditures as a percent of GDP under (i) current law; (ii) an alternative to current law in which physician payment rates are not as constrained as required by the SGR formula; and (iii)* ***an alternative with both an SGR modification as above and assumed payment rate increases for other providers that are not as constrained as required by the productivity adjustments****."* (page 62- emphasis added)

The report indicates that there was extensive discussion of the long-term viability of both types of payment reductions. While there was agreement among panel members that health care could be provided more efficiently, there was less agreement over the long-term viability of providers in the face of payment reductions of this magnitude. The Panel did not attempt to reach consensus on this particular issue and concluded that, "it is not possible to determine an unequivocal, "yes or no" answer to the long-range viability question" (page 63). The Panel, however, did recommend the alternative projection because it would be "…prudent to consider the potential financial consequences for the Medicare program should these existing payment provisions be repealed (or otherwise not implemented)."

Table 1
What are the potential alternatives to be considered and potential advantage and disadvantages of each?

Alternative	Pros	Cons
Maintain the alternative scenario as is Eliminate the alternative scenario	• No evidence that the policy process will play out the same way it did with the SGR. The alternative scenario was introduced in the context of SGR well after there was strong evidence that current law would not be implemented. In other words, it seemed fairly certain that the alternative scenario was closer to current law than "current law" was. Congress has not yet acted to overturn the productivity adjustments or MACRA. However, it has not shown any interest in staffing the IPAB. • Creates a sense of inevitability that provider payment cuts will be overturned. Similarly, it could be interpreted as the more likely outcome.	• Based on past experience, cuts to provider payment rates are unlikely to be sustainable. The alternative presents a potentially more realistic scenario and, thus, more accurately conveys the true financial state of the Medicare program. • The alternative scenario provides information on the implications of changes to current law that Congress could use before deciding to make those changes.
Maintain the alternative scenario but change the scenario	• The alternative scenario targets particular policies as being less certain/sustainable than others. Are these the right policies to consider when addressing policy uncertainty? • Within these policies are there certain assumptions in the implementation of the alternative scenario that should be reviewed. For example, should we assume that Congress will update payments to reflect the Medicare Economic Index growth rate or something lower or higher?	• Changing the alternative scenario would make subsequent reports different from prior ones in potentially confusing ways. Though it's not easy to justify any particular alternative in detail, it may be harder still to justify multiple different alternatives across different reports.
Incorporate the alternative scenario into the more general "uncertainty" analysis	• Since Congress has not yet overturned/altered current law and, in fact, has actually implemented it in many cases, should we think of this as more general "policy uncertainty" than as an alternative scenario? If so, how would this affect the presentation? More generally, we can think of two types of uncertainty: policy and economic/demographic. Perhaps should consider them together?	• There may not be a clear way to systematically vary policy or to select a likely range of variation.

What studies or research exists that could be used to support one or more of these alternatives?

The key issue in evaluating the sustainability of the payment reductions is how providers respond. Will they be able to improve productivity in order to maintain profitability? Will the steps providers take in response to payment reductions maintain levels of quality and access at a level that is acceptable to the public? Or will payment reductions be overturned before they even have implications for access and quality as they were in the case of the SGR?

The prior committee reviewed a substantial amount of research on how providers could potentially respond to payment changes. They focused primarily on payment reductions but also reviewed research on the effects of alternative payment models. (See Chapter IV of the report of the 2010–2011 panel.)

In the list below, we identify research developments since the last report (2010 or later), focusing on the studies or types of studies that would help us better understand how providers will respond to these payment changes in order to evaluate their likely fiscal impact on the Medicare program as well as their likely sustainability.

- Evidence on the implications of the productivity adjustments on non-physician behavior
  - Hospital cost shifting literature: recent literature suggests that hospitals do not raise prices to price insurers when Medicare reduces payment rates, rather they maintain or even reduce prices to private insurers (Frakt 2013; White 2013; Dranove, Garthwaite and Ody 2013). This could be relevant for thinking about the extent to which Medicare payment cuts will affect access to physician services. If private rates fall along with Medicare's, then access for Medicare beneficiaries may not suffer as much.
  - New literature on hospital productivity (see Romley et al. 2015 Health Affairs) and some literature reviews on productivity (see Sheiner review for Brookings Institute conference).

- Evidence on the implications of MACRA on physician behavior
  - Physician price setting literature: recent research suggests that private insurer prices for physician services also move with Medicare prices (Clemens and Gottlieb forthcoming JPE)

- Evidence of the effects of new payment models on Medicare spending and provider productivity.
  - See the work by McWilliams on ACOs (many papers).

Though we're not aware of research relevant to the following questions, they are germane to the issues:

- Can physicians become more productive? What are physician productivity growth rates, historically? Can they employ cheaper labor (nurses)?

- Are there any significant problems today with Medicare beneficiary access to physicians (stratified by specialty)? Are there any warning signs? What about looking at Medicaid?

- Discussion of how MACRA/MIPS and APMs will ultimately be implemented and the potential implications for care delivery.

- The political economy of the SGR reductions. Is anything different now?

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

All the researchers referenced above could likely offer insight based on their work. In addition:

- If there's an expert on MACRA and the reasoning behind the rates in it (why they're reasonable and achievable), that would be helpful. Who would that be?

- Also an expert on how MIPS is likely to be implemented would be helpful.

- There are lots of folks knowledgeable about Medicaid and physician access (Steven Zuckerman and others at Urban, for instance). Probably MAC PAC could also inform this.

- With respect to the political economy of the SGR, perhaps in contrast to MACRA, we might see if Jon Oberlander has some thoughts. David Jones also comes to mind, though we're not sure if he's focused on Medicare in his work (easy to make an inquiry).

Appendix 1:

Figure 1-1. 2012 Report

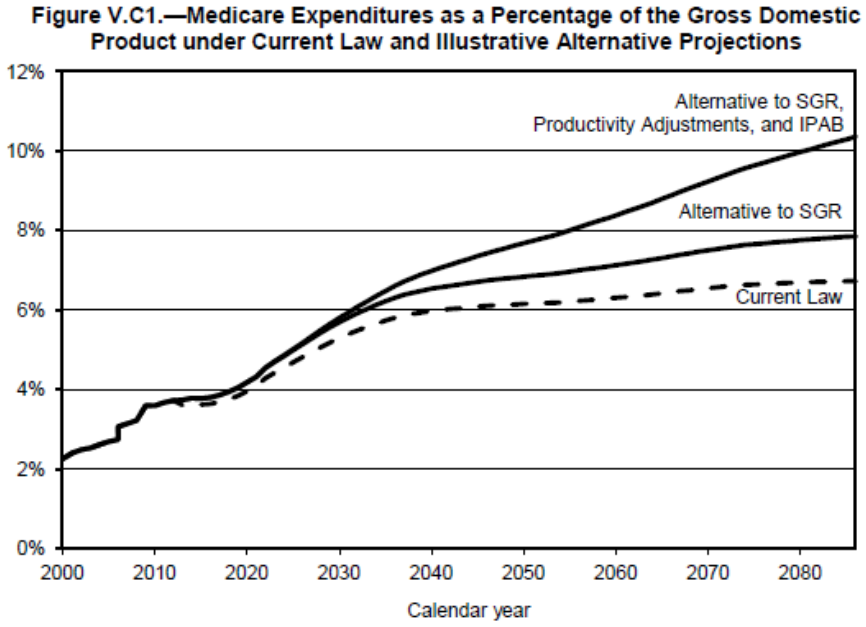


Figure 1-2. 2013 Report

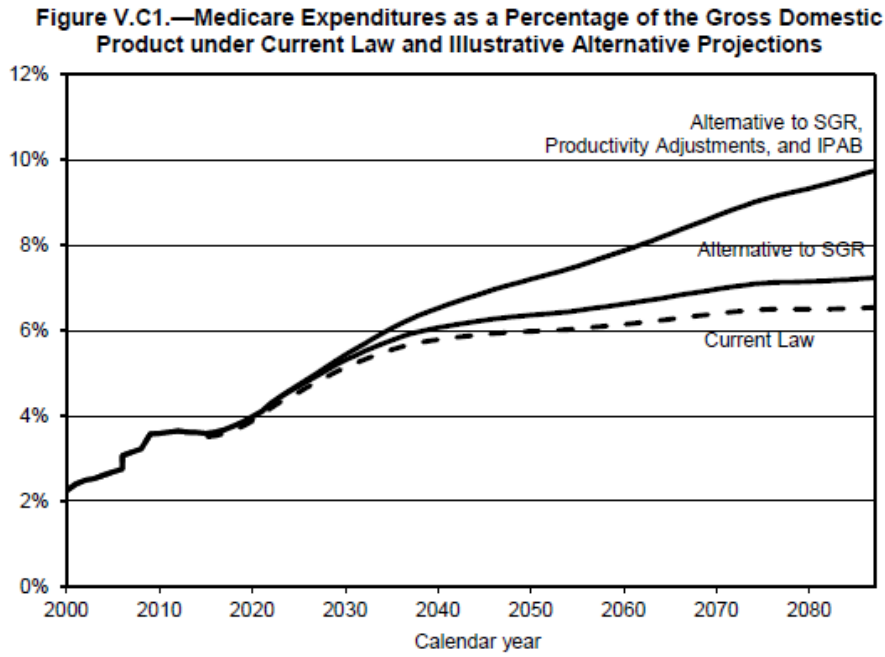


Figure 1-3. 2014 Report

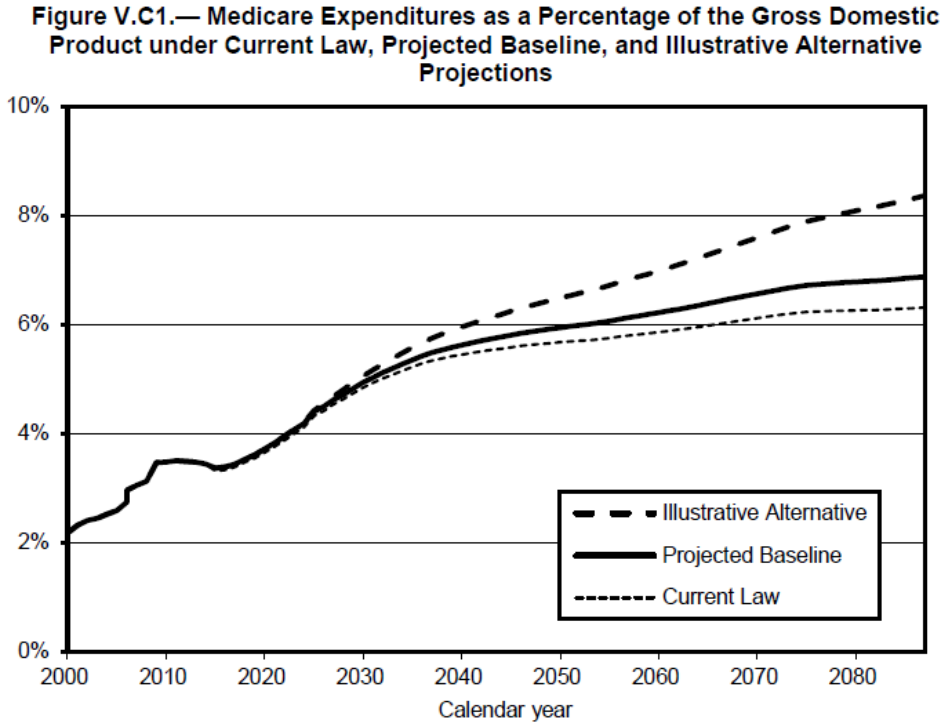


Figure 1-4. 2015 Report