

U.S. House of Representatives Committee on the Budget

“Center for Medicare and Medicaid Innovation:  
Scoring Assumptions and Real-World Implications”

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Thank you for the opportunity to testify today about the Center for Medicare & Medicaid Innovation, or CMMI, a vital cost control and quality improvement tool created under the Affordable Care Act.

### **Addressing health care cost growth**

I would like to begin my testimony with some context. We all know that the rapid growth in health care costs is a longstanding problem. It consumes federal and state budgets, squeezing out critical investments in education, infrastructure, and early childhood. It makes necessary care unaffordable for patients. And it drives up costs for employers and the middle class, eroding their disposable income.

Over the last few years, we have witnessed an extraordinary slowdown in the growth of health care costs. Since 2010, growth in Medicare spending per enrollee has actually been negative, and growth in private insurance spending per enrollee has averaged only 1.1% per year.<sup>1</sup> Although the recession and its lingering effects most likely explain most of the slowdown in private insurance, economic factors cannot explain the slowdown in Medicare.<sup>2</sup>

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<sup>1</sup> Barack Obama, *United States Health Care Reform: Progress to Date and Next Steps*, Journal of the American Medical Association, August 2, 2016, available at: <http://jama.jamanetwork.com/article.aspx?articleid=2533698>.

<sup>2</sup> Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Congressional Budget Office, August 2013, available at: [http://www.appam.org/assets/1/7/Why\\_Has\\_Growth\\_in\\_Spending\\_for\\_Fee\\_for\\_Service\\_Medicare\\_Slowed.pdf](http://www.appam.org/assets/1/7/Why_Has_Growth_in_Spending_for_Fee_for_Service_Medicare_Slowed.pdf).

I am not here to argue that the Affordable Care Act is responsible for all or even most of the slowdown. There is some evidence that the law is a contributing factor.<sup>3</sup> But whatever the cause, policymakers must act proactively to lock in the slowdown as soon as possible.

One approach is to shift costs and risks to beneficiaries, which may prevent them from accessing necessary care. The other approach, which I believe is bipartisan, is to reform the payment and delivery system to reward value and quality. For instance:

- Rep. Black (R-TN) is sponsoring the Comprehensive Care Payment Innovation Act of 2015, which directs the Secretary to implement bundled payments for episodes of care, including for joint replacement and coronary artery bypass graft (CABG).<sup>4</sup>
- Rep. McKinley (R-WV) and Chairman Price (R-GA) sponsored the Bundling and Coordinating Post-Acute Care Act of 2014, which mandated reform of post-acute care payments into bundled payments.<sup>5</sup>
- Several conservative experts have also recommended reforms that bundle payments for episodes of care.<sup>6</sup>

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<sup>3</sup> Council of Economic Advisers, *2014 Economic Report of the President*, March 2014, available at: [https://www.whitehouse.gov/sites/default/files/docs/full\\_2014\\_economic\\_report\\_of\\_the\\_president.pdf](https://www.whitehouse.gov/sites/default/files/docs/full_2014_economic_report_of_the_president.pdf).

<sup>4</sup> H.R. 2502, *The Comprehensive Payment Care Innovation Act of 2015*, 114<sup>th</sup> Congress, available at: <https://www.congress.gov/bill/114th-congress/house-bill/2502/text>.

<sup>5</sup> H.R. 4673, *The Bundling and Coordinating Post-Acute Care Act of 2014*, 113<sup>th</sup> Congress, available at: <https://www.congress.gov/bill/113th-congress/house-bill/4673/text>.

## **An innovative policy approach**

This is why the Center for Medicare & Medicaid Innovation is such an important cost control tool. The Center has the authority to test reforms and to expand them if they are successful. Thanks to the Center, Medicare already makes 30% of payments through alternative payment models, up from none in 2010.<sup>7</sup>

At its heart is the concept of evidence-based policymaking – a concept that is common sense and enjoys widespread bipartisan support. For instance, Congress unanimously passed the Evidence-Based Policymaking Commission Act of 2016, sponsored by Speaker Paul Ryan (R-WI).<sup>8</sup>

Critically, the Center must be able to design demonstrations in a way that we can be confident of the results. As the Congressional Budget Office has explained, voluntary demonstrations are subject to “selection bias” in which the participants are not representative of most providers:

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<sup>6</sup> Joseph Antos, Saving Medicare: A Market Cure for an Ailing Program, American Enterprise Institute, available at: [https://www.aei.org/wp-content/uploads/2014/09/-saving-medicare-a-market-cure-for-an-ailing-program\\_091959519048.pdf](https://www.aei.org/wp-content/uploads/2014/09/-saving-medicare-a-market-cure-for-an-ailing-program_091959519048.pdf). (See, e.g., p. 48: “Shifting toward bundled payments...would promote more efficient delivery of the services in the bundle.”) American Enterprise Institute, *Medicare makeover: Five responsible reforms to make Medicare healthy*, available at: <https://www.aei.org/feature/medicare-makeover-five-responsible-reforms-to-make-medicare-healthy/>; Douglas Holtz-Eakin, *Modernizing Medicare: An important first step*, The Hill, March 6, 2015, available at: <http://thehill.com/blogs/congress-blog/healthcare/234794-modernizing-medicare-an-important-first-step>.

<sup>7</sup> U.S. Department of Health and Human Services, *HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule*, March 3, 2016, available at: <http://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html>.

<sup>8</sup> H.R. 1831, *The Evidence-Based Policymaking Commission Act of 2016*, 114<sup>th</sup> Congress, available at: <https://www.congress.gov/bill/114th-congress/house-bill/1831>.

The main problem in evaluating such voluntary initiatives is that the hospitals that opted to participate were probably more capable of changing the ways they deliver care, and more likely to succeed financially, than hospitals that decided not to take part.<sup>9</sup>

Simply put, it could not have been the intent of Congress to hamstring the Center such that the results of a demonstration could not be extrapolated. Not only would this have been extremely wasteful, it also would not have adhered to the principles of evidence-based policymaking.

But perhaps more importantly, voluntary initiatives are unlikely to drive payment reform. In order to affect spending on a large scale, they must have broad participation. But to attract a significant number of participants, they must reduce the financial risk to participants and/or increase the financial rewards – which limits the potential savings. Voluntary payment reforms, in other words, are a classic Catch-22 paradox.

### **Comprehensive Joint Replacement (CJR) demonstration**

This Catch-22 is why it was so important that the Center launched its first mandatory demonstration, the Comprehensive Joint Replacement (CJR) program. This program builds upon the experience of the Bundled Payments for Care Improvement (BPCI) initiative. But it also builds upon experience and results from the Acute Care Episode Program, which bundled payments for 37 orthopedic and cardiac procedures. This previous demonstration improved the quality of care across 22 measures and achieved

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<sup>9</sup> Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023*, November 2013, p. 224, available at: <https://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf>.

savings, primarily from hospitals negotiating lower prices for medical devices.<sup>10</sup> Clearly, CJR was not launched into a vacuum.

According to the Institute of Medicine, spending on post-hospital care is the primary driver of variation in Medicare spending across areas.<sup>11</sup> Bundled payments that include post-acute care, like the CJR demonstration, are therefore key to reducing wasteful Medicare spending.

Although the Center has not yet reported results from the demonstration, I can relay to you results from one major health system. Northwell Health, which includes 21 hospitals in New York, has boosted the share of patients who are discharged to home (rather than to an expensive facility) from 30% to about 50%.<sup>12</sup> I can also report to you the results of my mom's successful knee replacement at a hospital in Rhode Island participating in bundled payments. My mom was discharged to home, receiving visits from a physical therapist and a nurse. This experience was better for her and for the health care system.

## **Part B drug demonstration**

For drugs administered by physicians, Medicare reimburses providers for the average sales price (ASP) of a drug plus a 6% markup, or 106% of ASP. This formula artificially

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<sup>10</sup> Maura Calsyn and Ezekiel J. Emanuel, *Controlling Costs by Expanding the Medicare Acute Care Episode Demonstration*, Journal of the American Medical Association, September 2014, available at: <http://archinte.jamanetwork.com/article.aspx?articleId=1885468&guestAccessKey=e0c47485-5500-4964-8f2e-2278693f3f93>.

<sup>11</sup> Institute of Medicine, *Variation in Health Care Spending: Target Decision Making, Not Geography*, 2013, available at: <http://www.nap.edu/catalog/18393/variation-in-health-care-spending-target-decision-making-not-geography>.

<sup>12</sup> Northwell Health, *Comprehensive Care for Joint Replacement*, September 2016.

inflates drug costs for some of the costliest drugs. As a result, Medicare spending on these drugs has increased by more than 10% per year since 2009.<sup>13</sup>

To address this problem, the Center has proposed reducing the 106% payment and supplementing it with a flat fee. Because average sales price is an average and the prices that providers pay may vary around this average, critics are concerned that the proposal will not fully reimburse the cost of drugs for some providers.

The variation of prices around the average sales price is an empirical question. For the highest-spending drugs, the vast majority of prices are less than 102% of ASP.<sup>14</sup> Thus, a 6% cushion is generally unnecessary and somewhat arbitrary; critics might as well demand a 10% add-on.

Moreover, substantial evidence from the real world indicates that drug manufacturers respond to such pricing reforms by lowering prices and narrowing price variation. It turns out that just as work expands to fill the time available for its completion, so do drug prices change and vary to fill the available margin.

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<sup>13</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2016, Table 5-1, available at: <http://www.medpac.gov/docs/default-source/reports/chapter-5-medicare-part-b-drug-and-oncology-payment-policy-issues-june-2016-report-.pdf?sfvrsn=0>.

<sup>14</sup> Kim Neuman, *Part B drug payment policy issues*, March 3, 2016, available at: <http://www.medpac.gov/docs/default-source/meeting-materials/march-2016-meeting-presentation-part-b-drug-payment-policy-issues.pdf?sfvrsn=0>.

After the sequester reduced drug payments from 106% to 104.3% of ASP in 2013, prices for most drugs dropped.<sup>15</sup> Similarly, after Congress significantly reduced drug margins in 2005, the reform did not affect cancer patients' access to treatment – and in some cases it improved their access.<sup>16</sup> In each of these cases, the same concerns were raised that you are hearing today. Evidence from the real world indicates that these concerns were misplaced.

### **Status quo is not an option**

When it comes to Medicare payment for services and drugs, the status quo is not an option. Although concerns are always raised about the impact of reforms on access to care, we forget that the status quo is what actually threatens access to care – by driving up costs and coinsurance payments.

Congress wisely created the Center for Medicare & Medicaid Innovation as a cost control tool that employs evidence-based policymaking. It is now much more difficult for special interests that are financed by the drug industry or that financially benefit from the status quo to thwart long overdue reforms.<sup>17</sup> To keep the brake on health care costs, the Center must be allowed to act with urgency to set expectations about a pathway to payment reform; we simply cannot afford a protracted period of inaction or uncertainty.

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<sup>15</sup> “These data suggest that some manufacturers may have responded to the sequester by changing their pricing patterns in a way that mitigated the effect of the sequester on some providers.” Medicare Payment Advisory Commission, June 2016, p. 125.

<sup>16</sup> Alisa M. Shea et al., *Association Between the Medicare Modernization Act of 2003 and Patient Wait Times and Travel Distance for Chemotherapy*, *Journal of the American Medical Association*, July 9, 2008; Joeelle Y. Friedman et al., *The medicare modernization act and reimbursement for outpatient chemotherapy*, *Cancer*, November 15, 2007.

<sup>17</sup> Joseph Antos argues that CMMI is a “partial solution” to the problem of political interference. See fn6, p. 46.