



Testimony

CBO's Estimates of the Budgetary Effects of the Center for Medicare & Medicaid Innovation

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Chairman Price, Ranking Member Van Hollen, and Members of the Committee, thank you for inviting me to testify about the Congressional Budget Office's estimates of the budgetary effects of the Center for Medicare & Medicaid Innovation.

The center was established in 2010 under the Affordable Care Act. It conducts demonstration projects that test new ways to deliver and pay for health care in certain programs, especially Medicare, trying to identify approaches that reduce spending and improve quality. The center's process for conducting those demonstrations marks a shift from how demonstrations were conducted in the past. For example, the Secretary of Health and Human Services has the authority to expand all approaches tested by the center that meet certain criteria.

CBO expects the center to reduce federal spending by about \$34 billion over the next 10 years. That estimate is based on judgments of how effectively the center will identify, refine, and expand approaches that reduce spending. Such judgments are inherently uncertain, however. CBO is monitoring the center's implementation of demonstrations and will update its assessments as more information becomes available.

In what follows, I will first review the use of Medicare demonstration projects by the Department of Health and Human Services (HHS) before the establishment of the center. Next, I will discuss how it was designed and what it has done since its inception. I will then explain how CBO incorporates the budgetary effects of the center's activities into its 10-year budget projections, as well as how CBO estimates the potential effects of legislation that would interact with those activities. Finally, I will outline what CBO might learn from the center's experiences in the next few years.

How Did HHS Conduct Demonstration Projects Before the Center Was Created?

Before the center was created, HHS long conducted demonstration projects to test new ways to deliver and pay for health care for Medicare beneficiaries. The demonstrations were either initiated by HHS (acting under its statutory authority) or mandated by legislation. Most did not reduce federal spending, though a few did. One notable success found that competitive bidding for durable medical equipment, such as oxygen equipment and walkers, reduced Medicare spending.

In 2012, CBO reviewed two broad categories of demonstrations that HHS had conducted before the establishment of the center.¹ The first, disease management and care coordination demonstrations, sought to improve care and reduce spending for beneficiaries with chronic illnesses and for those whose health care was expected to be particularly costly. The second category, value-based payment demonstrations, gave health care providers financial incentives to improve the quality and efficiency of care, rather than payments based strictly on the number and complexity of services delivered.

In nearly every disease management and care coordination demonstration, CBO found, government spending was at least as high as the spending that would have occurred in the absence of the demonstration. Among the value-based payment demonstrations, making bundled payments that covered all hospital and physicians' services for heart bypass surgeries reduced Medicare's total spending, but the other demonstrations appeared to produce small or no savings for Medicare. The demonstrations of disease management and care coordination had little or no effect on the quality of care, and two of the value-based payment demonstrations improved quality slightly.

In several ways, the process through which demonstrations were developed and implemented hampered HHS's ability to identify approaches that would reduce spending. Many demonstrations were mandated by legislation, which limited HHS's ability to modify them on the basis of early experience or to terminate them if they proved unsuccessful. In some cases, the legislation imposed constraints on HHS involving the geographic areas or providers that could be included, which did not necessarily improve the chances of identifying successful approaches. HHS also generally lacked the authority to expand demonstrations if they were successful. In addition, funding constraints limited HHS's ability to develop and test demonstrations, according to the Medicare Payment Advisory Commission. Finally, some demonstrations were designed in a way that did not allow robust evaluation—so even in cases when a demonstration might have achieved savings, it was impossible to attribute those savings to the demonstration.

1. Congressional Budget Office, *Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment* (January 2012), www.cbo.gov/publication/42860.

CBO's ability to determine which specific demonstrations would produce savings was limited at the time (and remains so). Therefore, on the basis of the considerations just described, CBO judged that most proposals to establish demonstration projects would, like the average project, be unlikely to reduce federal spending.

How Does the Center Conduct Demonstration Projects Differently?

The Affordable Care Act provided the center with \$10 billion to develop, test, and evaluate demonstration projects for fiscal years 2011–2019, and it provided an additional \$10 billion for each subsequent decade. The center may use those funds to finance demonstrations in Medicare, Medicaid, and the Children's Health Insurance Program. So far, however, most of the demonstrations conducted by the center have been in Medicare. CBO expects that to continue to be the case, in part because most of HHS's demonstrations were in Medicare over a long period before the center was established.

CBO's analysis of the center has focused on assessing the budgetary effects of demonstrations, although they may have effects on quality as well. In CBO's judgment, several aspects of the center's process for conducting demonstrations increase the likelihood of finding approaches that achieve federal savings. (That assessment is primarily based on judgments about the effectiveness of the process, not on judgments about the expected results of particular demonstrations.) Those aspects include the following:

- Current law specifies a robust mechanism for the center to solicit, screen, and develop new ideas to be tested.
- The center prioritizes demonstrations that can be empirically evaluated by means of appropriate data sources, adequate sample sizes, and other rigorous research methods—including valid methods of estimating outcomes in relation to what they would have been in the absence of the demonstration.
- The center may modify demonstrations on the basis of early experience to improve the chances of implementing a project in a way that achieves savings.

- The set amount of funds to develop and test demonstrations that is supplied under current law creates an incentive to end unsuccessful demonstrations and redirect funds to other demonstrations.
- The Secretary of Health and Human Services has the authority to expand a demonstration if doing so is expected either to decrease spending without harming quality or to improve quality without increasing spending. Medicare's Chief Actuary must certify the expected effects on spending before the expansion may proceed.

The second of those points mentions a key challenge facing the center: evaluating the effects of demonstrations on Medicare spending, using (among other things) valid methods of estimating what outcomes would have been in the absence of the demonstrations. Such estimates require comparing the outcomes of beneficiaries included in a demonstration with the outcomes of a similar group of beneficiaries who were not included. It is especially hard to attribute effects to a particular demonstration when several related changes are occurring in the health care system at the same time. Similarly, when health care providers' or beneficiaries' participation in a demonstration is voluntary, and when they are able to determine how a demonstration might affect them before deciding whether or not to participate, analysts must determine whether those who opted to participate differ sharply enough from the others to make the two groups not comparable.

If participation is voluntary, one way to compare outcomes is to assign participants randomly either to a treatment group (which experiences a new model for health care) or to a control group (which does not). Because participants in the two groups are expected to be similar, analysts can compare their outcomes. A less powerful approach is to use statistical methods to compare the outcomes of beneficiaries who choose to participate with the outcomes of those who choose not to—but again, it can be hard to draw valid conclusions if the two groups are substantially different.

An approach that is more powerful than either of those is to require some beneficiaries or providers to participate in the demonstration and to compare their outcomes with those of similar beneficiaries or providers who were excluded. That approach, which the center has used, is very effective at determining whether a demonstration

reduced spending and how, if it did, it could be expanded to a larger group that the participating population is representative of. (In contrast, those who participate voluntarily in demonstrations are generally not representative of larger groups, and voluntary demonstrations are therefore less useful in predicting effects on spending and identifying challenges in implementation.) According to most of the experts that CBO consulted, requiring participation in demonstrations helps the center conduct rigorous evaluations that are capable of identifying successful approaches.

What Has the Center Done So Far?

The center has pursued a range of demonstration projects in different parts of the Medicare program (see Table 1). For instance, several demonstrations encourage health care providers to manage the care furnished to a group of patients, a model known as accountable care; others bundle all payments to health care providers that are associated with an episode of care, a model known as episode-based payments. On its website, the center has published information about demonstrations' performance, in terms of cost and quality.

Medicare's Chief Actuary has certified that two demonstrations meet the statutory requirement that expansion would not increase Medicare spending. One of them, called Pioneer—a demonstration of an accountable care organization that gives doctors, hospitals, and other providers financial incentives to work together to improve quality and reduce spending—would generate savings if expanded, the Chief Actuary certified. The other, a program that tries to prevent or delay diabetes among high-risk beneficiaries by encouraging healthier lifestyles, would not increase Medicare spending if expanded, according to the Chief Actuary.

Determining the long-term effects of demonstration programs is challenging, and such analyses are often subject to considerable uncertainty. The Chief Actuary's certification of the diabetes prevention program relied partly on an evaluation from an independent contractor, and it also drew heavily from its own analysis and from the findings of prior research, although it did not include the potential costs that would result from increasing the lifespans of beneficiaries. The Secretary of Health and Human Services has announced plans to expand the diabetes prevention program so that it covers all Medicare beneficiaries.

No other decisions have been made about expanding demonstration programs.

How Are the Center's Activities Incorporated Into CBO's 10-Year Budget Projections?

CBO estimates that the center's activities will reduce federal spending, almost entirely for Medicare, by about \$34 billion from 2017 through 2026. Specifically, CBO projects that the center will spend about \$12 billion to conduct demonstrations and that those activities will reduce spending on Medicare benefits by about \$45 billion (see Table 2). The effects on federal spending are larger in the later years of CBO's baseline and are projected to be about 0.7 percent of net Medicare spending in 2026. Those estimates are based on CBO's independent judgment of how effectively the center will conduct demonstration projects.

Projecting what the center will spend to conduct demonstrations is relatively straightforward. The center receives \$10 billion every 10 years, but for its first few years, as it ramped up its operations, it did not spend a full \$1 billion per year. It therefore has resources to spend slightly more than \$1 billion per year over the next decade, and CBO projects that it will do that.

How the center's demonstrations will affect spending on Medicare benefits—and thus the federal costs or savings resulting from the center's activities—is more uncertain. A given set of demonstrations started in a particular year will increase federal costs at first, CBO projects. But over time, as HHS continues and then expands the successful demonstrations in that set and cancels the unsuccessful ones, the result will be savings. (Success refers to a decrease in spending without harming quality or an improvement in quality without increasing spending.) The budgetary effect of the center's activities thus depends partly on how many sets of demonstrations are in their initial (cost-increasing) stages and how many are in their later (cost-reducing) stages. CBO's projections incorporate the following judgments:

- HHS will generally expand demonstrations that succeed, and the expansions will yield federal savings.
- Demonstrations that succeed will operate for four to seven years, on average, before HHS decides whether to expand them.

Table 1.

Selected Demonstrations Conducted by the Center for Medicare & Medicaid Innovation

Accountable Care	
Pioneer Accountable Care Organization Model	This model began in 2012. It provides financial incentives for health care providers to form accountable care organizations (ACOs), in which the providers work together to coordinate care and reduce spending. The ACOs share savings and costs (relative to a predetermined benchmark) with the government and are evaluated on how they improve the quality of care. In 2015, Medicare's Chief Actuary certified that expanding the model would reduce net spending on Medicare.
Comprehensive ESRD Care Model	This model began in 2015. It provides financial incentives for dialysis facilities, nephrologists, and other providers to form ESRD seamless care organizations (ESCOs), which coordinate care for Medicare beneficiaries with end-stage renal disease (ESRD). ESCOs assume responsibility for the medical spending of beneficiaries who are assigned to them, as well as for the quality of care received by those beneficiaries. On the basis of what those beneficiaries spend in relation to a predetermined benchmark, ESCOs share savings and costs with the government.
Episode-Based Payment	
Comprehensive Care for Joint Replacement Model	This model, which began in April 2016, bundles payments for an episode of care associated with hip and knee replacements, trying to encourage hospitals, physicians, and providers of post-acute-care services to work together to coordinate care. Providers are paid under the normal Medicare fee-for-service payment schedule. They will also receive an additional payment, or have to make a payment to Medicare, on the basis of how the actual spending of the episode compares with a target price. Providers must meet certain quality benchmarks. The project operates in 67 metropolitan areas, and most of the roughly 800 hospitals in those areas are required to participate.
Oncology Care Model	This model began in July 2016 in order to find out whether improved care coordination could improve care and reduce spending. In the model, a physician's practice receives a care management fee when a Medicare beneficiary begins an episode of chemotherapy treatment. The practice is then eligible for an additional payment that is based on the extent to which it restrains costs and maintains quality. An episode begins with the start of chemotherapy and lasts six months. The Centers for Medicare & Medicaid Services (CMS) requires practices to meet certain guidelines, including some that involve the quality of care. CMS, 17 private payers, and nearly 200 practices are participating in the model.
Primary Care Transformation	
Comprehensive Primary Care Initiative	This project began in October 2012 and pays a monthly management fee to primary care practices to support primary care. Such care includes coordinating care with patients' other providers, encouraging patients to make decisions about their care, and developing personalized care plans. If beneficiaries' Medicare spending turns out to be lower than predetermined targets (which vary by region), the practices can receive part of the savings. The project is taking place at 441 sites in seven regions; 38 public and private payers are participating. It is scheduled to end in December 2016.
Comprehensive Primary Care Plus Model	This model is scheduled to begin in January 2017 and to run for five years in 14 regions. It builds on the Comprehensive Primary Care Initiative by testing whether various payment arrangements to promote primary care affect spending or the quality of care. CMS, state Medicaid agencies, and private insurers will participate in the model. Participating practices may choose from two tracks: one in which payments are based more on the number of beneficiaries treated, and one in which payments are based more on the amount of care received.
Medicaid and Children's Health Insurance Program (CHIP) Populations	
Strong Start for Mothers and Newborns Initiative	This initiative began in 2013. It tests prenatal care interventions for women who are enrolled in Medicaid or CHIP and who are at risk for having a preterm birth, trying to identify approaches that reduce preterm births, improve the health of mothers and babies, and decrease health care spending. So far, the project has awarded \$41 million to providers of obstetric care, state Medicaid agencies, Medicaid managed care organizations, and other providers that are serving women in areas with high rates of preterm birth. As of March 2016, the initiative was operating at 199 provider sites in 30 states and serving 23,000 women. It is scheduled to end in 2017.

Continued

Table 1.

Continued

Selected Demonstrations Conducted by the Center for Medicare & Medicaid Innovation

Medicare–Medicaid Enrollees

Financial Alignment Initiative for Medicare–Medicaid Enrollees	This initiative was announced in 2011, and states began participating in 2013. It permits states to adopt new models to integrate Medicare and Medicaid benefits for dual-eligible beneficiaries—that is, people who are eligible to receive benefits from both programs at the same time—as well as new models to better align the financing of the two programs. A preliminary evaluation of the initiative in the state of Washington shows reductions in monthly Medicare costs per beneficiary; a Medicaid cost analysis was not included in that evaluation.
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents	This initiative, which began in September 2012, seeks to reduce avoidable hospitalizations and to improve the quality of care in long-term care facilities by providing preventive care to dual-eligible beneficiaries. In the first phase of the initiative, seven enhanced care and coordination provider organizations—groups including a total of 143 long-term care facilities—participated. Six of those organizations will continue to participate in the second phase of the initiative, which begins in late 2016 and will last four years. An evaluation of 2014 data shows no significant improvement of quality in the initiative, though evaluation will continue.

New Payment and Service Delivery Models

Home Health Value-Based Purchasing Model	This model began in January 2016 and will run through 2022. It operates in nine states, and all home health agencies in those states are required to participate. (Such agencies provide skilled nursing services and other services in a patient's home.) The project will rank the agencies by the quality of care that they provide and adjust payments retroactively on that basis. Those adjustments begin in 2018, increase over time, and involve sharing costs as well as savings with the government.
Medicare Advantage Value-Based Insurance Design Model	This model will begin in January 2017 and run for five years. It will give Medicare Advantage plans in 7 states (and in 10 states, beginning in 2018) more flexibility involving enrollees with certain chronic conditions. The plans will be allowed to lower those enrollees' out-of-pocket payments in order to encourage them to use high-value interventions and providers. Under current law, plans are required to offer uniform benefits to all enrollees.

Adoption of Best Practices

Medicare Diabetes Prevention Program	This project began in 2013. It encourages healthier lifestyles among Medicare beneficiaries who have a high risk of developing diabetes, trying to prevent or delay the onset of that disease. The project uses a range of interventions, including dietary coaching and programs that encourage beneficiaries to be active. Medicare's Chief Actuary has certified that expanding this project would not increase spending on Medicare. In July 2016, the Secretary of Health and Human Services proposed to expand the project.
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Sources: See the list on page 11.

- Demonstrations that do not succeed will operate for two to five years, on average, before HHS cancels them.
- The center will take some time to establish its procedures before achieving a steady state of testing, evaluating, and expanding demonstrations. Earlier sets of demonstrations may achieve slightly smaller savings than later sets, because the center is expected to learn more about conducting demonstrations.

The budgetary effect of the center's activities also depends on how many completed sets of demonstrations have resulted in cost-reducing expansions. Because little information is available so far about the results of demonstrations initiated by the center, CBO's expectations on that

point rely primarily on evidence from earlier periods showing that a small share of demonstrations resulted in savings, most had little or no effect on Medicare spending, and some increased Medicare spending. CBO anticipates that in each year's set of demonstrations, any single project will achieve savings similar to those achieved in the past, on average. The agency also projects that demonstrations that appear to generate savings will be more likely to be expanded than in the past and that others will be more likely to be canceled. Over the whole of the coming decade, if only a few demonstrations reduce Medicare spending by the same percentages that followed from the most successful past demonstrations, and if those demonstrations were then expanded, the savings in CBO's baseline would be realized. Such savings could also result from a larger number of smaller effects.

Table 2.

Effects on Spending of the Activities of the Center for Medicare & Medicaid Innovation

Billions of Dollars

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017- 2026
Spending by the Center ^a	1	1	1	1	1	1	1	1	1	1	12
Reductions in Spending on Medicare Benefits	-1	-2	-2	-3	-4	-5	-6	-7	-7	-8	-45
Total	*	-1	-1	-2	-3	-4	-5	-5	-6	-7	-34

Source: Congressional Budget Office.

Amounts are for fiscal years. Numbers may not add up to totals because of rounding.

* = between -\$0.5 billion and zero.

a. The center received \$10 billion of budget authority in 2011 and is scheduled to receive \$10 billion in 2020.

CBO's 10-year projection does not reflect any assessment of particular demonstrations. The projection does incorporate the judgment that future Administrations will continue to use the authority granted to the center and the Secretary of Health and Human Services under current law. That judgment is shared by most experts whom CBO has consulted, including former Medicare officials serving under Presidents from both political parties. CBO expects the types of demonstrations to change under new Administrations—perhaps dramatically—but it has no basis for assessing whether those different demonstrations would be more or less effective in reducing federal spending.

On the basis of all those considerations, CBO estimates that the total effect of a set of demonstrations started in a given year will be an eventual reduction in certain Medicare spending of about 0.1 percent each year, on average. That Medicare spending refers to gross spending for Part A (Hospital Insurance) and Part B (Medical Insurance, which covers doctors' services, outpatient care, home health services, and other medical services). For example, the set of demonstrations begun this fiscal year are expected to reduce spending by a total of about \$1 billion in 2026; for each year's set, that amount could be higher or lower, but unexpectedly high amounts from some sets are anticipated to offset unexpectedly low amounts from others.

The limited information available so far indicates that the center has operated in a way that, for the most part, is consistent with CBO's projections. It has selected demonstrations that test a range of different approaches to delivering and paying for health care, mostly in the Medicare

program; designed demonstrations that can be evaluated in a rigorous way; and spent about \$4 billion through the middle of 2016 on developing, conducting, and modifying demonstrations. As CBO has obtained new information, the agency has updated those projections—for example, after a start that was slower than expected, the center scaled up its spending faster than CBO had initially estimated.

At this point, however, there is little information that CBO can use to further update its estimates. For example, in its March 2016 baseline, CBO projected that in 2017, spending by the center would be \$1 billion and the reduction in spending on Medicare benefits would be \$1 billion. That reduction is projected to come mainly from demonstrations in their later stages, prior to any expansion. Much of the projected reduction comes from demonstrations for which evaluations including estimated budgetary effects are not yet available, and those projections stem from expectations that are based on similar activities undertaken in the past. Unlike the center's spending, the reduction in spending on Medicare benefits will never be able to be observed; instead, that reduction will always be estimated in relation to what overall Medicare spending would have been if the center had never been established. Regarding projections about years further in the future, little new information has become available about spending on specific demonstrations or about how the center will expand successful ones.

CBO's estimate that the center's activities will reduce federal spending by \$34 billion from 2017 through 2026 is substantially higher than the corresponding 10-year estimate that the agency released in 2010, mostly because

different years were included in that earlier estimate. In 2010, CBO estimated that the center's activities would reduce federal spending by \$1.3 billion from 2010 through 2019. CBO expected the center's activities in its initial years to be devoted largely to the development and design of demonstrations, resulting in an increase in federal spending through 2015. After enough demonstrations are implemented that their expected savings would more than offset the costs of their operation, CBO projects, total spending resulting from the center's activities will be reduced. Both CBO's 2010 estimate and its 2016 baseline showed total savings of less than \$500 million for 2017, about \$1 billion in 2018, and about \$1 billion in 2019. For later years, CBO projects larger savings, reaching \$7 billion in 2026.

CBO is unable to assess how accurate its projections of the effects of the center's activities on federal spending have been so far for the same reasons that there is little information that CBO can use to update its projections for 2017. In particular, many of the demonstrations initiated by the center are in their early stages, and evaluation reports are not yet available for all of them.

How Does CBO Estimate the Potential Effects of Legislation That Interacts with the Center's Activities?

Many proposals that interact with the center's activities are of two types: those that would prevent the center from taking certain actions and those that would require certain actions that overlap with those that the center might undertake under current law. CBO has been asked to estimate the budgetary effects of many such proposals, and the agency applies some general principles when doing so. It also considers the specific circumstances of each case. Furthermore, CBO always seeks to consult with the Congressional staff members who are developing a proposal, aiming to understand the proposal better, to discuss evidence related to its likely effects, and to explain relevant analysis that the agency has undertaken.²

Proposals Preventing Actions

When asked to estimate the cost of a legislative proposal that would prevent the center from conducting a specific

demonstration project, CBO assesses how much is known about the potential budgetary effects of that demonstration. For most demonstrations that have not yet been tested, CBO has no basis for judging how conducting or preventing that particular demonstration would change spending. However, because CBO expects that the center's overall process of testing, evaluating, and expanding demonstrations will produce savings, on average, proposals that prevent demonstrations from occurring would tend to reduce those average savings and thus increase spending. When CBO does have a basis for estimating how a specific project would affect federal spending, the agency incorporates that information into its estimate.

If a legislative proposal would prevent the center from taking action in ways that affected several demonstrations, it could reduce savings significantly. For example, that would occur if the center was prevented from conducting several demonstrations that required beneficiaries or providers to participate, CBO has judged. Also, if a proposal included a statutory requirement that would delay a demonstration, CBO would generally conclude that it reduced savings—because the center's process of conducting demonstrations leads to savings, on average, and that process would be delayed and somewhat disrupted.

Proposals Requiring Actions

For legislative proposals that would require actions, CBO assesses the likelihood that the center would have taken a similar action under current law. That assessment lets CBO avoid double-counting budgetary effects—that is, counting the same effect twice, first as an effect that had already been incorporated into CBO's baseline projections and second as the effect of the proposal.

In making that assessment, CBO accounts for how much interest the center has shown in actions that are similar—either in terms of the tools that would be used (for example, the management of prescriptions before a hospital discharge) or in terms of the opportunities for savings that are targeted (such as avoiding hospital readmissions). CBO looks at both tools and targets because, though multiple tools may address the same problem, the resulting savings can often be realized only once. For example, although many approaches may try to reduce hospital readmissions, a given readmission can be avoided only once. If a proposal required the center to conduct a demonstration with the goal of reducing hospital

2. For more discussion, see Paul Masi and Tom Bradley, "Estimating the Budgetary Effects of Legislation Involving the Center for Medicare & Medicaid Innovation," *CBO Blog* (July 30, 2015), www.cbo.gov/publication/50692.

readmissions, CBO would have to determine if other demonstrations were already trying to achieve that goal and whether the resulting savings were already accounted for in the agency's baseline projections.

In some cases, proposals requiring actions that overlap with those that the center might have taken anyway would increase federal spending. When CBO has arrived at that conclusion, it has generally been for one or more of the following reasons:

- The proposal would limit HHS's flexibility in designing and refining a demonstration, thereby reducing the likelihood that it would succeed and the magnitude of expected savings if it did succeed. (Last year, for example, CBO examined a proposal that would have reduced the center's flexibility in testing a value-based insurance design for Medicare Advantage plans.)
- The proposal would permit or require a demonstration to be expanded even if it failed to meet the criteria (including actuarial certification) that are specified in current law. Such a proposal could make the expansion of a cost-increasing model more likely—because under current law, the agency expects, the center will terminate cost-increasing models.

Other legislative proposals that interact with the center's efforts would reduce federal spending, in CBO's assessment. CBO reaches that conclusion for one or more of the following reasons:

- The proposal would expand a demonstration that HHS has decided not to expand even though an evaluation conclusively showed that it reduced spending.
- CBO has enough information to estimate that a particular demonstration would probably reduce spending, and the legislative proposal is to implement it faster than the center had planned. The acceleration would thus increase the estimated savings. (Two years ago, for example, a proposal was made to accelerate a demonstration in which some nonemergency ambulance transportation required prior authorization.)
- HHS has decided to expand a successful demonstration on a voluntary basis, but the proposal would make the implementation mandatory. (Three years ago, for example, CBO estimated that implementing bundled payments and reducing Medicare's payments

for those bundles by a specified percentage nationwide could generate federal savings; the center had already begun testing such approaches on a voluntary basis.)

What Does CBO Hope to Learn About the Center in the Next Several Years?

CBO's assessment of the budgetary effects of the center's activities involves judgments that are inherently uncertain. Over time, however, CBO will learn more about the center's operations, including its approaches to selecting and testing, evaluating, and expanding demonstration projects. That information will help CBO improve its budget projections. Also, as the center evaluates more demonstrations, CBO hopes to gain a greater understanding of the characteristics of those that successfully reduce spending and of those that do not.

Selection and Testing of Demonstration Projects

CBO monitors the demonstration projects that the center selects for testing, and in the future, its projections will be informed by answers to the following questions, among others:

- What demonstrations has the center selected?
- Does it tend to select demonstrations that are focused on reducing spending or on improving quality?
- As it tests demonstrations, does it modify them on the basis of early experience?

Although CBO's budget projections do not rely on the specific number of projects that the center conducts (because projects vary widely in scale), the projections will improve as CBO learns more about the scope of the center's operations. One challenge in that learning process is that the center operates demonstrations under different statutory authorities, sometimes making it hard to know whether a particular demonstration should properly be considered the center's or not.

Evaluation of Demonstration Projects

CBO also monitors the center's evaluation process, several aspects of which are still being worked out. Answers to questions like the following could affect CBO's budget projections in the future:

- How appropriate are the sources of data that are used to evaluate the demonstrations?

- Are the sample sizes sufficient?
- How rigorous are the research methods?
- How does HHS respond if an evaluation does not provide credible evidence for its conclusions?
- Will the center terminate demonstrations that do not demonstrate savings?
- How long will it wait to end, modify, or expand demonstrations?
- What information from the evaluations will it make public?
- What are the average savings to be expected from a group of demonstrations started in the same year?

The center is required to make results from evaluations public in a timely fashion. So far, HHS has posted many of those results on the Internet. But in many cases, the available results are only for the initial years of a demonstration, which is generally not enough data to allow analysts to assess the demonstration's effects.

Expansion of Demonstration Projects

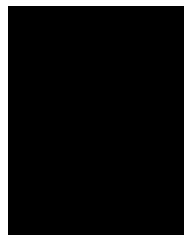
The savings that CBO expects to result from the center's activities stem largely from the judgment that successful demonstrations will be expanded and achieve savings. But the center is only now beginning to signal how it will decide to expand demonstrations. CBO will monitor several aspects of the expansion process, focusing on questions such as the following:

- Does the center expand demonstrations that achieve savings?
- Does it expand demonstrations in a way that increases potential savings, using lessons that were learned from testing the demonstrations?
- Is expansion voluntary or mandatory?

Also, CBO has limited information about the standards that Medicare's Chief Actuary will use in certifying that demonstrations may be expanded. HHS has, however, made public the statements that the Chief Actuary has issued in certifying two demonstrations eligible for expansion. As the center evaluates more demonstrations and decides whether or not to expand successful ones, CBO will update its projections, using the information that is made available.

This testimony was prepared by Paul Masi and Lyle Nelson, with contributions from Zoë Williams and with guidance from Tom Bradley and Holly Harvey. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, this testimony contains no recommendations.

Mark Hadley, Keith Hall, and Jeffrey Kling reviewed the testimony. Benjamin Plotinsky edited it, and Maureen Costantino prepared it for publication. An electronic version is available on CBO's website (www.cbo.gov/publication/51921).



Sources of Information in Table 1

Pioneer Accountable Care Organization Model

Paul Spitalnic, *Certification of Pioneer Model Savings* (Centers for Medicare & Medicaid Services, Office of the Actuary, April 2015), <http://go.usa.gov/xWbsj> (PDF, 363 KB).

Comprehensive ESRD Care Model

Center for Medicare & Medicaid Innovation, “Comprehensive ESRD Care Initiative: Frequently Asked Questions” (accessed August 30, 2016), <http://go.usa.gov/xW5kG> (PDF, 187 KB).

Comprehensive Care for Joint Replacement Model

Center for Medicare & Medicaid Innovation, “Comprehensive Care for Joint Replacement Model: Frequently Asked Questions” (accessed August 30, 2016), <http://go.usa.gov/xW5kz> (PDF, 923 KB).

Oncology Care Model

Centers for Medicare & Medicaid Services, “Oncology Care Model” (June 29, 2016), <http://go.usa.gov/xW58C>.

Comprehensive Primary Care Initiative

Center for Medicare & Medicaid Innovation, “Comprehensive Primary Care Initiative” (July 27, 2016), <http://go.usa.gov/xW58W>.

Comprehensive Primary Care Plus Model

Center for Medicare & Medicaid Innovation, “Comprehensive Primary Care Plus” (August 29, 2016), <http://go.usa.gov/xW5yY>.

Strong Start for Mothers and Newborns Initiative

Ian Hill and others, *Strong Start for Mothers and Newborns Evaluation: Year 2 Annual Report*, vol. 1, *Cross-Cutting Synthesis of Findings* (submitted by the Urban Institute, Health Management Associates, American Institutes for Research, and Brilljent to

the Center for Medicare & Medicaid Innovation, March 2016), <http://go.usa.gov/xW58d> (PDF, 8.0 MB).

Financial Alignment Initiative for Medicare–Medicaid Enrollees

Center for Medicare & Medicaid Innovation, “Financial Alignment Initiative for Medicare–Medicaid Enrollees” (August 30, 2016), <http://go.usa.gov/xW59T>.

Edith G. Walsh, *Measurement, Monitoring, and Evaluation of the Financial Alignment Initiative for Medicare–Medicaid Enrollees* (submitted by RTI International to the Centers for Medicare & Medicaid Services, January 2016), <http://go.usa.gov/xW599> (PDF, 1.4 MB).

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

Center for Medicare & Medicaid Innovation, “Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents” (April 8, 2016), <http://go.usa.gov/xW59A>.

Center for Medicare & Medicaid Innovation, “Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two” (April 8, 2016), <http://go.usa.gov/xW5XY>.

Melvin J. Ingber and others, *Evaluation of the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Final Annual Report Project Year 3* (submitted by RTI International to the Center for Medicare & Medicaid Innovation, January 2016), <http://go.usa.gov/xW5XQ> (PDF, 2.2 MB).

Home Health Value-Based Purchasing Model

Center for Medicare & Medicaid Innovation,
“Home Health Value-Based Purchasing Model”
(July 15, 2016), <http://go.usa.gov/xW5Xw>.

**Medicare Advantage Value-Based Insurance
Design Model**

Centers for Medicare & Medicaid Services,
“Medicare Advantage Value-Based Insurance

Design Model” (August 10, 2016), <http://go.usa.gov/xW55x>.

Medicare Diabetes Prevention Program

Paul Spitalnic, *Certification of Medicare Diabetes
Prevention Program* (Centers for Medicare & Medicaid Services, Office of the Actuary, March 2016),
<http://go.usa.gov/xW55j> (PDF, 364 KB).