



## CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

January 24, 2014

### **S. 1871** **SGR Repeal and Medicare Beneficiary Improvement Act of 2013**

*As reported by the Senate Committee on Finance on January 16, 2014*

#### **SUMMARY**

S. 1871 would replace the Sustainable Growth Rate (SGR) formula, which determines the annual updates to Medicare's payment rates for physician services, with new systems for establishing those payment rates; extend a number of health care and human services programs and provisions that would otherwise expire; and make other modifications to Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and several human services programs.

CBO estimates that enacting S. 1871 would increase direct spending by \$150.4 billion over the 2014-2023 period. (The legislation would not affect federal revenues). Pay-as-you-go procedures apply to this legislation because it would affect direct spending.

In addition, implementing the bill would affect spending subject to appropriation, but CBO has not estimated all of those potential discretionary effects. S. 1871 would authorize specified funding levels for certain activities within the Department of Health and Human Services (HHS). Together, those specified authorizations would result in outlays of less than \$0.1 billion over the 2014-2023 period, assuming the appropriation of the authorized amounts.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

#### **ESTIMATED COST TO THE FEDERAL GOVERNMENT**

The estimated budgetary impact of S. 1871 is shown in the following table. The costs of this legislation fall within budget functions 500 (education, training, employment, and social services), 550 (health), and 570 (Medicare).

By Fiscal Year, in Billions of Dollars												
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
<b>CHANGES IN DIRECT SPENDING OUTLAYS<sup>a</sup></b>												
<b>Title I: Medicare Payment for Physician Services</b>	5.2	10.1	10.1	10.2	9.7	11.0	12.3	13.6	15.1	14.1	45.3	111.5
<b>Title II: Extensions and Other Provisions</b>												
<b>Subtitle A: Medicare Extensions</b>												
Geographic Practice Cost Index	0.1	0.4	0.6	0.6	0.6	0.7	0.7	0.8	0.8	0.9	2.4	6.2
Therapy Services	0.6	0.4	0.5	0.7	0.8	0.9	1.0	1.1	1.3	1.4	3.1	8.8
Ambulance Services	0.1	0.1	0.1	0.1	0.1	*	*	*	*	*	0.5	0.5
Medicare-Dependent Hospitals	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.6
Low-Volume Hospitals	0	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.6	0.6	1.7	4.5
Medicare Special Needs Plans	0	*	0.3	0.4	0.2	0.2	0.2	0.1	0.1	0.1	1.0	1.7
Medicare Cost Contracts	0	0	0.1	0.1	*	*	*	*	*	*	0.2	0.2
Quality Measurement	*	*	*	*	0	0	0	0	0	0	0.1	0.1
Outreach	0	*	*	*	*	*	*	*	*	*	0.1	0.2
<b>Subtitle B: Medicaid and CHIP Extensions</b>												
Qualifying Individual Program Transitional Medical Assistance	0.5	0.8	1.0	1.2	1.4	0.9	0.3	0.3	0.2	0.2	5.0	6.9
Express Lane Eligibility	0.3	0.6	0.3	0.1	0	-0.3	-0.1	*	0	0	1.2	0.8
Pediatric Quality Measures	0	*	0	0	0	0	0	0	0	0	*	*
Special Diabetes Programs	*	*	*	*	*	0	0	0	0	0	0	0
Special Diabetes Programs	*	0.3	0.3	0.3	0.3	0.3	*	*	0	0	1.2	1.5
<b>Subtitle C: Human Services Extensions</b>												
Extensions	*	*	0.1	0.1	0.1	0.1	0.1	*	*	*	0.4	0.7
<b>Subtitle D: Program Integrity</b>												
Program Integrity	*	*	*	*	*	*	*	*	*	*	0.1	0.3
<b>Subtitle E: Other Provisions</b>												
Other Provisions	*	0.1	0.4	0.6	0.6	0.6	0.7	0.8	0.8	0.9	1.6	5.5
<b>Independent Payment Advisory Board Interaction</b>												
Board Interaction	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>-0.4</u>	<u>-0.1</u>	<u>-0.1</u>	<u>-0.1</u>	<u>*</u>	<u>0</u>	<u>-0.6</u>
<b>Estimated Direct Spending Outlays</b>	<b>6.7</b>	<b>13.6</b>	<b>14.4</b>	<b>14.9</b>	<b>14.7</b>	<b>14.9</b>	<b>16.1</b>	<b>17.5</b>	<b>19.2</b>	<b>18.5</b>	<b>64.4</b>	<b>150.4</b>
<b>CHANGES IN SPENDING SUBJECT TO APPROPRIATION</b>												
Authorization Level	*	*	0.1	*	*	0	0	0	0	0	0.1	0.1
Estimated Outlays	*	*	*	*	*	*	0	0	0	0	0.1	0.1
<b>Memorandum</b>												
<b>Non-Scoreable Effects</b>												
Recovery Audit Contractors	0	*	*	*	*	*	*	*	*	*	*	-0.1
Extension of Medicaid Fraud Control Units Authority	0	*	*	*	*	*	*	*	*	*	-0.1	-0.3
Redirecting Civil Monetary Penalties	*	*	*	*	*	*	*	*	*	*	*	*

Notes: Components may not sum to totals because of rounding; \* = between -\$50 million and \$50 million.  
CHIP = Children's Health Insurance Program.

a. For most provisions, estimated changes in budget authority would be equal to estimated changes in outlays for direct spending.

## **BASIS OF ESTIMATE**

The Bipartisan Budget Act of 2013 (enacted as Public Law 113-67 in December of last year) made multiple changes to the Medicare program, including many of the payment systems and programs that would be affected by S. 1871—generally by extending for three months the payment rules that were in effect in 2013. As a result, conforming changes would have to be made for S. 1871 to have its intended effects. This estimate reflects the assumption that the legislation would include such conforming changes. In general, the estimate assumes that those overlapping provisions of S. 1871 would take effect after the period affected by the Bipartisan Budget Act of 2013 (in most cases, three months).

For two provisions—the 2014 update for services on the physician fee schedule and the extension of so-called “reasonable cost reimbursement contracts”—it was not obvious how a conforming change would be specified. For this cost estimate, CBO made the following assumptions:

- With respect to the physician fee schedule, the Bipartisan Budget Act of 2013 increased payment rates by one-half percent for services furnished during January through March of 2014. However, S. 1871 maintains payment rates at the 2013 level through 2023. This estimate assumes those payment rates would revert to the 2013 level on April 1, 2014.
- Both the Bipartisan Budget Act of 2013 and S. 1871 would extend by one year (through 2015) authority for reasonable cost reimbursement contracts (which specify the terms under which some managed care plans participate in Medicare) in areas that meet certain thresholds for competition among insurers. This estimate assumes that S. 1871 would extend those contracts through 2016.

Payments to Medicare Advantage (MA) plans are based on underlying fee-for-service (FFS) costs, so CBO estimates an interaction between changes in FFS spending and MA plan payments. In addition, beneficiary premiums (primarily for coverage under Parts B and D of Medicare, but also for Medicare Part A for a small number of individuals) offset some share of spending on Medicare services.<sup>1</sup> CBO therefore estimates an interaction between changes in FFS spending and the total amount of premiums paid by beneficiaries. Most estimates in the preceding table incorporate the effect of changes in FFS spending on MA spending and beneficiary premium collections. With respect to payments for physician services, those interactions are detailed below.

This estimate assumes that S. 1871 will be enacted in the spring of 2014.

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1. Medicare Part A finances inpatient hospital and skilled nursing care, among other services. Part B covers physician services and other outpatient care. Part D is Medicare’s outpatient drug benefit.

## Physician Payments

Title I of S. 1871 would change the way the Medicare program pays for services provided by physicians and other health care professionals. Medicare compensates physicians for services they provide on the basis of a fee schedule that specifies payment rates for each type of covered service. Payment rates are based on a measure of the resources required to provide a given service (measured in relative value units, or RVUs), adjusted to account for geographical differences in input prices, and translated into a dollar amount by applying a “conversion factor.” The SGR formula determines the annual update to the conversion factor. Under current law, Medicare’s payment rates for physicians’ services are slated to drop by about 24 percent in April 2014, and CBO projects those payment rates will increase by small amounts in most subsequent years but will remain below current levels throughout the next 10 years.

S. 1871 would replace the SGR with new payment systems over the next several years. The major provisions of the new payment systems specified in S. 1871 are described below:

- The bill would maintain Medicare’s payment rates for services on the physician fee schedule at the 2013 level through 2023, but the amounts paid to individual providers would be subject to adjustment through one of two mechanisms, depending on whether the physician chooses to participate in a Value-Based Performance Incentive (VBP) program or an Alternative Payment Model (APM) program. (Both programs are described at greater length below.) The Bipartisan Budget Act increased the physician payment rates by 0.5 percent for the first three months of calendar year 2014. This estimate assumes that conforming changes to S. 1871 would return payment rates to the 2013 level for the rest of calendar year 2014.
- Payments to providers who participate in the VBP program would be subject to positive or negative performance adjustments financed through a funding pool, with the positive and negative adjustments designed to be offsetting so they have no net effect on overall payments. The performance adjustments could be as large as 4 percent of the amounts paid on the physician fee schedule for services provided by physicians participating in the VBP program in 2017, and that percentage would increase to between 10 percent and 12 percent in 2021 and subsequent years. The performance adjustment for an individual provider would depend on that provider’s performance.
- Providers who participate in an APM program (in particular, those who receive a substantial portion of their revenue from alternative payment models) would receive, in 2017 through 2022, a lump-sum payment equal to 5 percent of their Medicare payments in the prior year for services paid on the physician fee schedule. Providers with revenue close to the APM revenue threshold either would receive no

adjustment to their Medicare payments or the VBP performance adjustment if they reported measures and activities in that program. Providers would not be eligible for a lump-sum payment in 2023.

- For 2024 and subsequent years, there would be two payment rates for services paid on the physician fee schedule. For providers paid through the VBP program, payment rates would be increased each year by 1 percent. For providers paid through an APM, payment rates would be increased each year by 2 percent.

In addition, the bill would eliminate current-law penalties for providers who do not achieve meaningful use of electronic health records (EHR) or satisfactorily report data on quality. However, physicians would have to meet standards for use of EHR and quality as part of the VBP program. In addition, the bill would adjust relative value units for certain physicians' services, and require the development of payment codes that would encourage care coordination and the use of medical homes.

**Value-Based Performance Incentive Program.** The legislation would establish a VBP system in which the total performance of physicians and other medical providers would be measured based on information reported by those providers regarding quality measures, clinical practice improvement activities, resource use, and meaningful use of electronic health records. The Secretary of Health and Human Services would develop a methodology to assess total performance and determine a composite score. Beginning in 2017, providers with higher composite scores would receive positive performance adjustments and providers with lower composite scores would receive no or negative performance adjustments. The performance adjustments would not increase Medicare spending because reductions in payments made to providers with lower composite scores would be used to provide higher performance adjustments to providers with higher composite scores.

The Secretary would establish a funding pool to be used to distribute VBP payment adjustments by modifying the amount paid for each service based on the provider's composite score. The funding pool would rise from 4 percent of payments under the physician fee schedule for services provided by physicians participating in the VBP program in 2017 to between 10 percent and 12 percent in 2021 and subsequent years.

**Alternative Payment Models.** From 2017 through 2022, certain providers who participate in eligible APMs would receive a lump-sum incentive payment equal to 5 percent of their aggregate payments from Medicare for the preceding year. The legislation specifies the following types of Medicare-eligible APMs:

- Models that: (1) require the provider to bear financial risk, meet standards related to the use of electronic health records, and meet quality measures comparable to the VBP program; and (2) are being tested through a demonstration program (or have

been expanded after being tested) under Medicare or the Center for Medicare and Medicaid Innovation (CMMI); or

- A medical home program expanded after a successful demonstration conducted by CMMI that meets standards related to the use of electronic health records and quality measures.

For 2017 and 2018, a provider would be eligible for the lump-sum payment of 5 percent if at least 25 percent of the provider's Medicare payments were for services furnished in an eligible APM. Providers who do not come within 5 percentage points of the Medicare share-of-revenue threshold would be subject to the rules of the VBP program. However, a provider who comes within 5 percentage points of meeting the threshold could choose between being paid the fee-schedule amount (without further adjustment) or being paid under the rules of the VBP program.

Beginning in 2019, the threshold for the share of revenue from eligible APMs necessary to be eligible for the lump-sum payment of 5 percent would rise, but the provider could count revenue from comparable non-Medicare APMs. Also beginning in that year, providers with revenue from an APM that is close to those thresholds would have a choice similar to that facing providers close to the thresholds in 2017 and 2018.

**Budgetary Effects of Title I.** CBO estimates that enacting title I of S. 1871 would increase direct spending by about \$45 billion over the 2014-2018 period and approximately \$112 billion over the 2014-2023 period, assuming enactment this spring. Nearly all of the estimated increase in spending would stem from the specified updates to rates for services paid on the physician fee schedule. CBO estimates that reverting to the 2013 payment rates for the rest of 2014 and maintaining the 2013 level through 2023 would increase Medicare spending by about \$109 billion over the 2014-2023 period.

In addition, CBO estimates that establishing the VBP and APM programs, with the opportunity for providers to choose to participate in only one of the programs, would increase Medicare spending by approximately \$5 billion through 2023. That estimate largely reflects CBO's expectation that each provider will choose the program that is most attractive financially to that provider.

Other provisions in title I would adjust RVUs for certain physician services; require the development of payment codes that would encourage care coordination and use of medical homes; and eliminate current-law penalties associated with not meeting quality or EHR standards. Those provisions would result in estimated net savings of about \$5 billion through 2023.

CBO's estimate of the budgetary effects of title I incorporates the effects of changes in Medicare spending for services furnished in the fee-for-service sector on payments to

Medicare Advantage (MA) plans, changes in receipts from premiums paid by beneficiaries, an increased likelihood that the Independent Payment Advisory Board (IPAB) mechanism would be triggered (discussed in the section on Extension of Medicare Provisions below), and changes in spending by the Department of Defense's TRICARE program owing to changes in Medicare payment rates. In particular:

- Spending for the MA program would rise because the “benchmarks” that Medicare uses to determine how much the program pays for MA enrollees are adjusted for changes in Medicare spending per beneficiary in the fee-for-service sector. There would be no impact on MA spending under S. 1871 until 2016 because the payment rates currently in effect through March of 2014 will be used to set benchmarks for 2015. The effect on MA would account for about \$39 billion of the total estimated increase in direct spending from title I over the 2015-2023 period.
- Beneficiaries enrolled in Part B of Medicare (which covers physicians' and other outpatient services) pay premiums that offset about 25 percent of the costs of those benefits. Such premium collections are recorded as offsetting receipts (a credit against direct spending). Therefore, about one-quarter of the gross increase in Medicare spending would be offset by changes in those premium receipts. Premiums for 2014 have been set, so changes to offsetting receipts for this legislation would begin in 2015. Over the 2015-2023 period, CBO estimates that aggregate Part B premium receipts would rise by about \$31 billion under title I.
- The TRICARE program pays Medicare coinsurance and deductibles for military retirees. Those coinsurance and deductible payments would be higher under the legislation because the prices of physicians' services in Medicare would be higher. CBO estimates that the effect on TRICARE from title I would increase direct spending by about \$1 billion over 10 years.

### **Extension of Medicare Provisions**

Subtitle A of title II would extend numerous Medicare provisions that would otherwise expire under current law. In total, CBO estimates that enacting those extensions would increase federal spending by about \$10 billion over the 2014-2018 period and approximately \$24 billion over the 2014-2023 period.

**Geographic Practice Cost Index.** Medicare payments for services provided under the physician fee schedule are adjusted to reflect geographic differences in the cost of providing services. That adjustment, which is based on the Geographic Practice Cost Index (GPCI), reflects the cost of operating a physician's practice in each area relative to the national average. From January 2004 through December 31, 2013, legislation prevented adjustments to the GPCI for physicians' work from falling below that average. Under

S. 1871, that floor on the work index would be made permanent. CBO estimates that provision would increase direct spending by about \$6 billion over the 2014-2023 period.

**Therapy Services.** As of January 1, 2015, the legislation would permanently repeal an annual per-beneficiary cap on Medicare payments for outpatient therapy services. Those caps are currently \$1,920 for physical therapy and speech-language pathology services combined and \$1,920 for occupational therapy services. In addition, S. 1871 would require the Secretary of HHS to develop a medical review program for outpatient therapy services to promote appropriate utilization. CBO estimates that provision would increase direct spending by about \$9 billion over the 2014-2023 period.

**Ambulance Services.** S. 1871 would extend add-on payments to certain providers of ground ambulance services in designated urban and rural areas. The legislation also would continue bonus payments to ground ambulance service providers in certain rural areas. Both types of supplemental payments would be extended until January 1, 2019. Beginning July 1, 2015, this legislation would require the reporting of cost information for certain ambulance service providers and permit a 5 percent reduction in payments (for a one-year period) for any ambulance provider who is required to report but does not do so. CBO estimates that those changes would increase direct spending by \$0.5 billion over the 2014-2023 period.

**Medicare-Dependent Hospitals and Low-Volume Hospitals.** The legislation would permanently extend payment provisions related to Medicare-dependent hospitals (MDHs) and low-volume hospitals (LVHs). MDHs would continue to be paid a blend of the amount determined under the prospective payment system applicable to most hospital services and a hospital-specific amount. For LVHs, S. 1871 would continue to provide a 25 percent increase in payment rates for hospitals with 200 or fewer total discharges; that adjustment would decrease on a sliding scale to 0 percent for hospitals with more than 1,600 total discharges. CBO estimates those provisions would increase direct spending by about \$6 billion over the 2014-2023 period.

**Medicare Special Needs Plans and Cost Contracts.** Special needs plans (SNPs), a category of MA plans offered by private insurers, enroll beneficiaries who require an institutional level of care, have certain chronic conditions, or are enrolled in both Medicare and Medicaid. S. 1871 would permanently authorize SNPs for institutionalized beneficiaries and extend the authorization for SNPs that enroll beneficiaries with certain chronic conditions through December 31, 2017. SNPs that target beneficiaries enrolled in both Medicare and Medicaid would be reauthorized through December 31, 2020, and would be required to integrate Medicare and Medicaid benefits to the extent permitted under state laws.

Under current law, some private health plans that furnish Medicare benefits are paid based on an assessment of their reasonable costs for providing services. S. 1871 would allow the



Secretary of HHS to renew, through 2016, those cost contracts that are scheduled to cease under current law because they operate in areas that meet certain thresholds for competition among insurers. Cost contract plans affected by this provision could convert to become a new MA plan in 2017 or would have their contract terminated beginning in 2017. CBO estimates that those changes to Medicare rules for SNPs and cost contract plans would increase direct spending by approximately \$2 billion over the 2014-2023 period.

**Other Provisions.** S. 1871 would provide funding for quality measurement activities and a variety of beneficiary education and outreach activities. CBO estimates those provisions would increase direct spending by \$0.3 billion over the 2014-2023 period.

**Independent Payment Advisory Board Interactions.** For 2015 and subsequent years, the IPAB is obligated to make changes to the Medicare program that will reduce spending if the rate of growth in spending per beneficiary is projected to exceed a target rate of growth linked to the consumer price index and per capita changes in nominal gross domestic product. CBO's projections of the rates of growth in spending per beneficiary in its May 2013 baseline are below the target rates of growth for fiscal years 2015 through 2023. However, enacting S. 1871 would increase Medicare spending, which would increase the likelihood that the IPAB mechanism would be triggered. CBO estimates the expected value of the savings from triggering the IPAB mechanism would be a \$0.6 billion reduction in Medicare spending over the 2015-2023 period.

### **Extension of Medicaid and CHIP Provisions**

Subtitle B of title II would extend several Medicaid and CHIP provisions, at a cost of about \$7 billion over the 2014-2018 period and approximately \$9 billion over the 2014-2023 period.

**Qualifying Individuals.** States receive Medicare funding to pay Medicare Part B premiums for beneficiaries, known as Qualifying Individuals (QIs), who earn between 120 percent and 135 percent of the Federal Poverty Level (FPL) and who meet certain asset requirements. S. 1871 would authorize and fund the QI program for calendar years 2014 through 2018, as well as remove restrictions on the number of beneficiaries who may receive QI assistance. CBO estimates that provision would increase direct spending by about \$7 billion over the 2014-2023 period.

**Transitional Medical Assistance.** Transitional Medical Assistance (TMA) extends Medicaid coverage for four months for families who otherwise would lose eligibility because their income has increased. A temporary expansion of TMA that provides 12 months of coverage will expire on March 31, 2014. S. 1871 would continue that expansion to 12 months of coverage through December 31, 2018. In addition, the bill would allow states to opt out of providing TMA if they adopt the option under current law to extend Medicaid benefits to people whose income is below 138 percent of the FPL and if they

provide 12 months of continuous eligibility to adults and children in Medicaid and CHIP. CBO estimates that this provision would increase direct spending by about \$0.8 billion over the 2014-2023 period.

**Express Lane Eligibility.** States may use data from other specified agencies to determine or re-determine children’s eligibility for CHIP. This “express lane” eligibility provision will expire on September 30, 2014. S. 1871 would extend the authority for states to use express lane eligibility determinations until September 30, 2015. CBO estimates that provision would increase direct spending by about \$20 million over the 2014-2023 period.

**Pediatric Quality Measures.** S. 1871 would redirect \$15 million of funding previously appropriated for adult quality measurement to pediatric quality measurement. This provision has no net budgetary impact over the 2014-2023 period.

**Special Diabetes Programs.** S. 1871 would appropriate \$150 million a year through fiscal year 2019 for each of two existing diabetes research, prevention, and treatment programs. The first program funds grants through the National Institutes of Health; the second funds grants through the Indian Health Service. CBO estimates that provision would increase direct spending by \$1.5 billion over the 2014-2023 period.

### **Human Services Extensions**

Subtitle C of title II would extend several human services grant programs: abstinence education, personal responsibility, family-to-family health information, and health professions opportunity. Those extensions would cost \$0.4 billion over the 2014-2018 period and \$0.7 billion over the 2014-2023 period.

### **Program Integrity**

Subtitle D of title II would increase funding to Medicare Recovery Audit Contractors (RACs), states, and the HHS Office of the Inspector General (OIG) to support efforts to reduce improper payments. CBO estimates that implementing those provisions would increase federal spending by \$0.3 billion over the 2014-2023 period. Specifically:

- Section 231 would mandate new education and outreach activities for the contractors who process Medicare fee-for-service claims, as well as a demonstration project related to the RACs. Section 231 also would allow the Secretary of HHS to retain a portion of the money recovered by the RACs and use the funds to support efforts that reduce improper payments. CBO estimates that section 231 would increase direct spending by about \$0.1 billion over the 2014-2023 period.

- Section 232 would authorize states that operate Medicaid fraud control units to investigate and prosecute complaints of abuse and neglect of Medicaid patients in home and community-based settings. States could receive federal reimbursement to support the costs of those activities. CBO estimates that those federal payments to states would total about \$0.2 billion over the 2014-2023 period.
- Section 233 would redirect 3 percent of civil monetary penalties collected from resolution of Medicare and Medicaid fraud to the HHS OIG. The OIG could use those funds for oversight and enforcement activities. CBO estimates that this provision would result in \$5 million in new funding for the HHS OIG over the 2014-2023 period. Those redirected funds would be considered new outlays because, under current law, those penalties will be deposited in the Treasury.

That increased spending on enforcement activities would decrease spending for Medicare and Medicaid benefits. Under Congressional scorekeeping rules, the estimated reduction in spending for benefits is not available to offset the increased spending on enforcement, although the reduction in spending for benefits would reduce future budget deficits.<sup>2</sup> CBO estimates that the “non-scoreable” savings from this subtitle would total about \$0.3 billion over the 2014-2023 period.

### **Other Provisions**

Subtitle E of title II includes a number of other provisions that would affect Medicare and Medicaid. CBO estimates that enacting the provisions in subtitle E would increase federal spending by about \$5.5 billion over the 2014-2023 period. Most of that spending would result from three sections:

- Section 249 would require a pilot study of remote monitoring of individuals receiving home health services, with the goal of reducing spending on those services. The pilot study would make bonus payments to participating home health agencies for which the total cost of services covered by Parts A, B, and D of Medicare for beneficiaries covered by the study were below those costs for beneficiaries not covered by the study; those bonus payments would equal 75 percent of the amount by which those total costs differed. If eligible beneficiaries were randomly assigned to participating home health agencies, that mechanism would result in bonus payments to half of the participating agencies—even if there were no change in how those agencies provide care. Because participating agencies have considerable ability to select which patients they serve, CBO estimates that 75 percent of participating home health agencies would receive bonus payments. After accounting for the effect on program spending of changes in how participating

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2. The Conference Report to the Balanced Budget Act of 1997 (P.L. 105-33) established a series of scorekeeping rules. Rule 14 states that “no increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for administrative or program management activities.”

home health agencies would provide care, CBO estimates that implementing that pilot program would increase Medicare spending by about \$1 billion over the 2014-2023 period.

- Section 254 would promote Medicaid beneficiary access to podiatrists and expand Medicare coverage of therapeutic shoes for beneficiaries with diabetes. CBO estimates that those changes would increase direct spending by about \$1 billion between 2014 and 2023.
- Section 255 would establish a demonstration program to improve access to community mental health services and would increase the federal government's share of Medicaid payments for those services. Those provisions would increase direct spending by about \$3 billion over the 2014-2023 period, CBO estimates.

The remaining provisions in subtitle E would have no budgetary effects or would cost less than \$50 million each over the 2014-2023 period, CBO estimates.

### **Spending Subject to Appropriation**

S. 1871 would also authorize specified funding levels for certain activities within HHS. Together, those specified authorizations would result in outlays of less than \$0.1 billion over the 2014-2023 period, assuming the appropriation of the authorized amounts.

- Section 241 would require the Secretary of HHS to establish a Commission on Improving Patient Directed Health Care and would authorize the appropriation of \$3 million per year for fiscal years 2014 and 2015 to support the Commission's activities.
- Section 255 would authorize the appropriation of \$50 million for fiscal year 2016 to support a demonstration program to improve community mental health services.

CBO has not estimated all potential discretionary effects for implementing the legislation. In particular, the estimate does not include the cost to HHS of administrative activities required to implement changes in program rules, nor does it include estimates of the cost of several studies that would be mandated by S. 1871 for which the amount of funding is unspecified.

### **PAY-AS-YOU-GO CONSIDERATIONS**

The Statutory Pay-As-You-Go (S-PAYGO) Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues for the current year and the 10 years beginning with the budget year as defined by the Balanced Budget

and Emergency Deficit Control Act. Beginning in January 2014, the budget year is fiscal year 2015, so the following S-PAYGO estimates run through 2024. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

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**CBO Estimate of Pay-As-You-Go Effects for S. 1871, as reported by the Senate Committee on Finance on January 16, 2014**

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	By Fiscal Year, in Billions of Dollars												2014-	2014-
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2019	2024	
<b>NET INCREASE IN THE DEFICIT</b>														
Statutory Pay-As-You-Go Impact	6.7	13.6	14.4	14.9	14.7	14.9	16.1	17.5	19.2	18.5	17.5	79.3	167.9	

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**INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT**

S. 1871 contains no intergovernmental mandates as defined in UMRA. Provisions of the bill would require states to provide extended assistance under Medicaid and to include podiatrists as physicians under the program. Because Medicaid provides states with significant flexibility to make programmatic adjustments in response to such changes in requirements, the new requirements would not be intergovernmental mandates as defined in UMRA. Other provisions relating to the Medicaid program would give states the option to participate in demonstration programs and to provide continuous eligibility to adults and children enrolled in Medicaid or CHIP. In total, CBO estimates that all of the bill’s provisions related to Medicaid would result in additional spending by states of about \$3.5 billion over the 2014-2023 period.

The bill contains no private-sector mandates as defined in UMRA.

**PREVIOUS CBO ESTIMATES**

On September 13, 2013, CBO estimated that enacting H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, as ordered reported by the House Committee on Energy and Commerce on July 31, 2013, would cost about \$175 billion over the 2014-2023 period. That legislation is comparable to title I of S. 1871. We have subsequently reduced that estimate to \$146 billion, reflecting two final actions. First, the Centers for Medicare and Medicaid Services published a final rule that announced the update to the conversion factor for the physician fee schedule for 2014 and other current-law adjustments. The revised payment rates, as well as other information provided

in the final rule, changed CBO's projections of Medicare payment rates for services provided on the physician fee schedule for 2014 and future years. Second, enactment of the Bipartisan Budget Act of 2013 temporarily sets updates to payment rates for services on the physician fee schedule to 0.5 percent from January 1, 2014, to March 31, 2014.

On January 24, 2014, CBO transmitted a cost estimate for H.R. 2810, the SGR Repeal and Medicare Beneficiary Access Act of 2013, as ordered reported by the House Committee on Ways and Means on December 12, 2013. CBO estimates that enacting the Ways and Means version of H.R. 2810 would increase direct spending by about \$121 billion over the 2014-2023 period. That legislation is also comparable to title I of S. 1871.

CBO's estimate for title I of S. 1871 is lower than both versions of H.R. 2810 primarily because of lower annual updates to payment rates for services on the physician fee schedule. While the APM structure in S. 1871 and the version of H.R. 2810 approved by the Ways and Means Committee are comparable, the lower annual update in S. 1871 would result in lower spending on physicians' services. Compared to the Energy and Commerce version, both title I of S. 1871 and the Ways and Means version of H.R. 2810 would have lower estimated costs associated with payments made through APMs.

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