



CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 13, 2013

H.R. 2810
Medicare Patient Access and Quality Improvement Act of 2013
As ordered reported by the House Committee on Energy and Commerce on July 31, 2013

SUMMARY

H.R. 2810 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. CBO estimates that enacting H.R. 2810 would increase direct spending by about \$175 billion over the 2014-2023 period. Pay-as-you-go procedures apply to this legislation because it would affect direct spending. (The legislation would not affect federal revenues.)

H.R. 2810 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws governing the evidentiary rules and practices of medical malpractice claims. CBO estimates that the costs of the intergovernmental mandate would be small and would not exceed the threshold established in UMRA (\$75 million in 2013, adjusted annually for inflation). The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2810 is shown in the following table. The costs of this legislation fall within budget functions 570 (Medicare) and 550 (health).

	By Fiscal Year, in Billions of Dollars											
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
CHANGES IN DIRECT SPENDING												
Estimated Budget Authority	9.0	13.5	13.5	13.5	14.0	16.5	19.5	22.0	25.5	28.5	63.5	175.5
Estimated Outlays	9.0	13.5	13.5	13.5	14.0	16.5	19.5	22.0	25.5	28.5	63.5	175.5

BACKGROUND AND MAJOR PROVISIONS

Under current law, Medicare's payment rates for physicians' services are slated to drop by about 24 percent in January 2014. CBO projects those payment rates will increase by small amounts in most subsequent years, but will remain below 2013 levels through the 2014-2023 period.

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.

Current law includes the opportunity for physicians to earn incentive payments for satisfactorily reporting quality data through the Physician Quality Reporting System (PQRS). H.R. 2810 would build upon this reporting system in replacing the SGR formula.

H.R. 2810 would replace the SGR formula with new payment systems over the next several years, phased in as follows:

- Between 2014 and 2018, the annual update to Medicare's payment rates for services on the physician fee schedule would equal 0.5 percent.
- Beginning in 2019, Medicare's payment rates for services on the physician fee schedule would be determined in two broad ways:
 - Payment rates would be based on a physician's performance in the Quality Update Incentive Program (QUIP), or
 - Physicians could choose to be paid for some or all of their Medicare services under an Alternative Payment Model (APM).

The bill also would modify payment rates in certain California counties, 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.

Quality Update Incentive Program

Under the QUIP, Medicare would continue to compensate physicians for services they provide on the basis of a fee schedule that specifies payment rates for each type of covered service. However, beginning in 2019, the annual update to the conversion factor would be 0.5 percent and the payment amount would be adjusted by a bonus or penalty based on how well a provider performed on certain quality measures and clinical practice improvement activities relative to thresholds stated in the bill. The legislation would establish a process to determine annual payment amounts as follows:

- Prior to 2019, professional societies and other stakeholders could submit to the Secretary of Health and Human Services (HHS) quality measures and clinical practice improvement activities that apply to a specific peer group (generally, a medical or surgical specialty or subspecialty).
- The Secretary would solicit public input, select measures and activities for each peer group from those that were submitted, and publish the final set prior to the “performance period.”
- The Secretary would determine a performance period (probably a one-year period ending 6 to 12 months before the start of a calendar year) that would be used to measure provider performance for the purpose of determining the adjustment to the conversion factor for the next calendar year.
- Each provider would choose the appropriate peer group for his or her services and would submit data on the measures and activities selected by the Secretary for that peer group to the Centers for Medicare and Medicaid Services (CMS).
- Payment rates for providers would be determined based on their performance relative to thresholds stated in the bill. In addition to the 0.5 percent annual update to the conversion factor:
 - Providers exceeding the top threshold would get a positive 1 percent adjustment;
 - Providers not meeting the lower threshold would get a negative 1 percent adjustment; and
 - Providers between the two thresholds would not be adjusted.
 - Additionally, providers who did not submit data on the quality measures would get a negative 5 percent adjustment.

Those adjustments to the updates would be determined separately for each provider, but the Secretary could also establish a process that would apply to groups of providers practicing together. The reporting requirements and payment adjustments under the QUIP would be in addition to the existing reporting requirements and payment adjustments under the PQRS

Alternative Payment Model

Beginning in 2019, the legislation also would allow providers to choose to participate in and be paid under alternative payment models. H.R. 2810 does not describe a specific payment model; rather, it would establish processes for developing and implementing such models.

The legislation would require the Secretary of HHS to enter into a contract with a private-sector organization referred to as the APM contracting entity. Provider organizations or other entities would submit proposed models to the contracting entity. The contracting entity would then recommend models to the Secretary that it concludes meet specified criteria, including that a given model would probably reduce Medicare spending without reducing the quality of care, or improve the quality of care without increasing spending. In developing those recommendations, the contracting entity would be authorized to modify a proposal to increase the likelihood that it would reduce Medicare spending or improve the quality of care. Depending on the contracting entity's assessment of the strength of the evidence that a particular model would reduce spending or improve the quality of care, the recommendation would specify that a model be either tested and evaluated in a demonstration project or incorporated directly into the Medicare program without such testing.

For models recommended for testing and evaluation through demonstration programs, the Secretary and the Chief Actuary of CMS would review the contracting entity's recommendations and analyses. The Secretary would be authorized to modify recommended models to increase the likelihood that they would reduce spending or improve the quality of care. The Secretary also would be authorized to waive requirements of title 18 of the Social Security Act, as needed, solely for testing and evaluating models under the demonstration program.

Models that undergo demonstration programs would operate for three years and would include evaluation by an independent evaluation entity. The legislation would allow the Secretary to modify or terminate during testing any demonstrations that were not meeting or expected to meet the specified criteria; demonstrations could also be extended by the Secretary. If a particular demonstration model proves successful, is recommended by the independent evaluation entity, and is certified by the Chief Actuary as meeting specified spending criteria, it would go through a process for final approval and implementation as a new payment model within the Medicare program.

The legislation specifies similar criteria and processes for models that the contracting entity recommends implementing without testing and evaluation. The independent evaluation entity would not be involved with such models. However, before such a model can be implemented, the Chief Actuary would have to certify that a model is expected not to increase program spending (a stricter criterion than would be applied for demonstration programs).

Under either APM track, providers would enter into a contract with the Secretary to participate in a specific model. Because such models could apply only to portions of a medical practice (such as models addressing particular medical conditions), providers could participate in more than one model, as well as the QUIP.

Separately, the bill would appropriate \$2 billion for items and services not eligible for Medicare payment under current law, payments for services that exceed current Medicare fee schedule amounts, and the administrative costs for the APM contracting entity and the independent evaluation entity.

BASIS OF ESTIMATE

Assuming enactment late in calendar year 2013, CBO estimates that enacting H.R. 2810 would increase federal direct spending by \$175.5 billion over the 2014-2013 period. The bill would eliminate the cuts in payment rates that will occur under current law for services on the physician fee schedule and instead set updates to payment rates for services on the physician fee schedule at 0.5 percent a year. CBO estimates those automatic updates would increase direct spending by \$63.5 billion through 2018, relative to the level of spending that CBO projects based on the payment rates under current law.

As described above, beginning in 2019, physicians would be able to choose between the QUIP and APM mechanisms and among APM options. The budgetary effects of the legislation would depend, therefore, on how the QUIP and APM mechanisms operate and on the proportion of spending affected by each of those mechanisms.

CBO considered a number of plausible outcomes in terms of both the share of Medicare spending for physicians' services that would be subject to payment under the QUIP and APM options, the relative cost of possible alternative payment models, and the savings that could accrue to the Medicare program through the use of APMs. Taking into account the effect of the automatic 0.5 percent annual update that would begin in 2014, CBO estimates that enacting the QUIP and APM mechanisms specified in H.R. 2810 would increase direct spending by about \$112 billion over the 2019-2023 period. That increase, in combination with the \$63.5 billion cost of the automatic updates during the 2014-2018 period, would result in a total increase in direct spending of \$175.5 billion over the 2014-2023 period.

CBO expects that physicians would generally choose to participate in the payment options that offer the largest payments for the services they provide. Their choices would depend, therefore, on the alternative payment models that become available. The legislation specifies processes and safeguards for APMs, but it does not provide any details about how payment rates would be determined for services furnished by providers participating in an APM. Thus, there is significant uncertainty about the alternative payment arrangements that would be offered, how rates would be set, how many models would be adopted, how many providers would participate, how beneficiaries would be assigned, and other issues.

CBO expects that the process specified in the legislation would result in the development and adoption of multiple APMs. During the 2019-2023 period, CBO anticipates that most spending through the APM mechanism would involve models being tested through demonstrations, because relatively few models would be likely to meet the criteria for operation without first being tested in demonstration programs.

CBO expects that most of the alternative payment models that would be adopted under this legislation would increase Medicare spending. That judgment is based both on the outcomes of previous demonstration projects in Medicare and on a comparison of the process specified in this legislation for identifying and adopting APMs with the process in current law for designing, testing, and adopting innovative payment systems.

CBO's review of numerous Medicare demonstration projects found that very few succeeded in reducing Medicare spending. Those demonstrations, which often tested approaches that had been applied previously to privately insured populations, generally involved providers whose characteristics made them particularly likely to be successful at controlling spending. However, despite those relatively favorable conditions, most of those demonstrations either increased spending or had no significant effect on spending.

Based on the lessons of prior demonstrations, Congress enacted legislation that established the Center for Medicare & Medicaid Innovation (CMMI). Two elements that distinguish the process of developing new approaches under CMMI from prior demonstrations are:

- CMMI has enhanced authority to end unsuccessful demonstrations. (Ending unsuccessful demonstrations in the past was often difficult because some constituencies benefitted from increased spending. Now, the costs of unsuccessful demonstrations come out of CMMI's budget, which provides a further incentive to end unsuccessful demonstrations.)
- CMMI has the authority to expand innovations that prove to be successful at reducing costs, improving the quality of care, or both.

The structure specified by H.R. 2810 would replicate the process being followed by CMMI in many ways. Although CMMI would continue to operate under the legislation, it is likely that some models that would, under current law, be developed by CMS (with input from providers) and then tested by CMMI would, under the bill, be developed by providers (with input from CMS) and then tested or implemented as APMs. CBO expects that the greater influence of providers within the design process specified in H.R. 2810 would lead to smaller savings than would arise from the development and adoption of new approaches through the CMMI process.

In addition, CBO expects that providers would tend to choose to participate in APMs that would increase their payments from Medicare. For example, those providers whose current practice style results in Medicare spending per patient that is below the average level of spending would tend to participate in APMs that would share some of the savings relative to that average level with those providers. More generally, different APMs would tend to use different measures of success. As various APMs were developed over time, it is likely that most physicians would be able to find and participate in an alternative payment model or set of models under which the physicians would appear to be better than average.

The CMS chief actuary must concur with the judgment of the APM contracting entity that a model recommended for testing and evaluation in a demonstration program has a potential for savings. CBO anticipates that some APMs would, in fact, result in savings. On balance, however, CBO expects that the use of the APM mechanism would tend to provide physicians with rewards for good performance even when there was no change in their performance relative to current law; that effect would tend to generate higher Medicare spending than under current law.

Payments to physicians who do not participate in an APM, and payment for services provided by a physician that are not encompassed by an APM, would be made under the QIIP. Because physicians would be able to select the set of measures that would be used to determine their eligibility for the additional payment adjustment of 1 percent, CBO expects that nearly all services furnished under the QIIP beginning in 2019 would be paid at 101 percent of the amount specified on the fee schedule. To be sure, some physicians would be subject to reductions of 1 percent or 5 percent for failure to meet the performance or reporting requirements, but CBO expects most such physicians would tend to be those for whom Medicare patients make up a small share of their practices. As a result, CBO anticipates that a very small share of Medicare spending for physicians' services would be subject to those reductions.

CBO's estimate of the budgetary effects of H.R. 2810 also includes the effects of several other changes to Medicare's physician payment system specified in the legislation; those other changes would have relatively small budgetary effects. In particular, the legislation would modify payment rates in certain California counties, 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. CBO estimates those provisions would cost \$0.3 billion over the 2014-2023 period.

CBO's estimate of the budgetary effects of the legislation incorporates the effects of changes in Medicare spending for services furnished in the fee-for-service sector on payments to Medicare Advantage (MA) plans and on receipts from Part B premiums paid by beneficiaries. In addition, the legislation includes the effects of changes in Medicare payment rates on spending by the Department of Defense's TRICARE program. The MA and TRICARE effects account for about \$68 billion of the total estimated increase in direct spending from the legislation over the 2014-2023 period:

- Medicare 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. The benchmarks have already been set for 2014 and would not be changed under the legislation, so there would be no impact on MA spending under H.R. 2810 until 2015.
- 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.
- Beneficiaries enrolled in Part B of Medicare 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 increase in Medicare spending would be offset by changes in those premium receipts. However, because CBO's estimate of H.R. 2810 assumes enactment late in calendar year 2013, the 2014 costs would not be included in the premium established for calendar year 2014, but would affect premiums in several subsequent years. Over the 2015-2023 period, CBO estimates that aggregate Part B premiums receipts would rise by about \$53 billion.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO Estimate of Pay-As-You-Go Effects for H.R. 2810, as ordered reported by the House Committee on Energy and Commerce on July 31, 2013

	By Fiscal Year, in Billions of Dollars											2014-	2014-
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2018	2023	
NET INCREASE IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	9.0	13.5	13.5	13.5	14.0	16.5	19.5	22.0	25.5	28.5	63.5	175.5	

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 2810 would shield health care providers from liability claims based on any federal guidelines or standards developed, recognized, or implemented under any health care provision of the Affordable Care Act. That provision would impose an intergovernmental mandate as defined in UMRA because it would preempt state laws that allow for the use of such guidelines or standards in medical malpractice claims. While the preemption would limit the application of state laws, CBO estimates that it would not impose significant costs and would fall well below the threshold established in UMRA for intergovernmental mandates (\$75 million in 2013, adjusted annually for inflation).

ESTIMATED IMPACT ON THE PRIVATE SECTOR

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

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