# CONGRESSIONAL BUDGET OFFICE
# COST ESTIMATE

April 8, 2003

# H.R. 810
## Medicare Regulatory and Contracting Reform Act of 2003

*As ordered reported by the House Committee on Energy and Commerce on March 26, 2003*

## SUMMARY

The Medicare Regulatory and Contracting Reform Act of 2003 would require the Centers for Medicare and Medicaid Services (CMS) to modify how Medicare regulations and policies are developed and enforced, and would modify the procedures used to resolve disputes involving payment for services covered by Medicare. The bill would transfer certain administrative law judges from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS). It would change the procedures by which Medicare makes contracts with entities to process and pay claims, and it would place new requirements on those contractors. It would require the Secretary of HHS to conduct several demonstrations, to initiate new outreach and education programs, and to complete several studies and reports. CBO estimates that implementing H.R. 810 would cost $68 million in 2004 and $1.6 billion over the 2004-2008 period, assuming appropriation of the necessary funds.

The procedural changes required by H.R. 810 would affect spending for services covered by Medicare, which is direct spending. However, many of the bill's requirements codify existing practices, while the other requirements would cause minor increases or decreases in spending for covered services. These changes could have significant impacts on direct spending in any given year, however, CBO estimates that the net change in direct spending would be insignificant over the 2004-2013 period.

H.R. 810 would expand an existing intergovernmental and private-sector mandate, as defined by the Unfunded Mandates Reform Act (UMRA), but CBO cannot estimate whether any new costs of complying with the mandate would exceed the thresholds established by UMRA. (In 2003, the thresholds are $59 million for intergovernmental mandates and $117 million for private-sector mandates.)

Under current law, the Secretary of HHS establishes standards for collecting and reporting health data based on the recommendations of the National Committee on Vital and Health Statistics (NCVHS). H.R. 810 would allow the Secretary to establish a new coding system without such a recommendation. This expanded authority could increase the cost of the existing mandate on public and private health plans and providers regarding the coding system they must use. Because such a change would depend on future actions of the Secretary, however, CBO does not have a basis for estimating the increased cost.

The bill also includes a requirement for public hospitals that participate in the Medicare program to comply with the Occupational Safety and Health Administration (OSHA) bloodborne pathogens standard. That requirement would be a condition of participating in the Medicare program, and thus not an intergovernmental mandate.

## ESTIMATED COST TO THE FEDERAL GOVERNMENT

The following table shows the estimated authorization levels and outlays for Medicare administrative expenses under current law and under H.R. 810. Assuming appropriation of the estimated amounts, CBO estimates that implementing H.R. 810 would cost $68 million in 2004 and $1.6 billion over the 2004-2008 period. The costs of this legislation fall within budget function 570 (Medicare).

| | By Fiscal Year, in Millions of Dollars | | | | | |
|---|---|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
| SPENDING SUBJECT TO APPROPRIATION [a] | | | | | | |
| Spending for Medicare Administrative Costs Under Current Law | | | | | | |
| Estimated Authorization Level [b] | 3,798 | 3,931 | 4,078 | 4,236 | 4,418 | 4,626 |
| Estimated Outlays | 3,797 | 3,925 | 4,064 | 4,209 | 4,377 | 4,579 |
| Proposed Changes | | | | | | |
| Estimated Authorization Level | 0 | 76 | 489 | 397 | 313 | 329 |
| Estimated Outlays | 0 | 68 | 448 | 406 | 321 | 327 |
| Spending for Medicare Administrative Costs Under H.R. 810 | | | | | | |
| Estimated Authorization Level | 3,798 | 4,007 | 4,567 | 4,633 | 4,731 | 4,955 |
| Estimated Outlays | 3,797 | 3,993 | 4,512 | 4,615 | 4,698 | 4,906 |

a. Enacting H.R. 810 also would affect direct spending, but CBO estimates there would be no significant net impact over the 2004-2013 period.

b. The 2003 level is the amount appropriated for that year. The 2004-2008 levels are baseline projections, which assume annual adjustments for anticipated inflation.

## BASIS OF ESTIMATE

For this estimate, CBO assumes that the legislation will be enacted July 1, 2003 and that the necessary amounts will be appropriated each year, beginning in fiscal year 2004.

### Spending Subject to Appropriation

Implementing H.R. 810 would require increased appropriations for the administration of Medicare. In particular, the bill would increase the costs to CMS for contracting, for adjudicating appeals, for education and outreach to providers and beneficiaries, and for developing new policies concerning the issuance of regulations and guidelines.

**Contracting Reform.** Under current law, CMS contracts with fiscal intermediaries and carriers to process and pay claims, to educate providers regarding Medicare billing policy, and for other purposes. This bill would change the activities required of contractors and the methods by which CMS enters into contracts and oversees the activities of contractors. CBO estimates that these provisions would increase the cost of administering contracts and the total amount CMS spends on contracts by $37 million in 2004 and $1.3 billion over the 2004-2008 period.

*Contracting Changes*. H.R. 810 would direct CMS to provide incentives to contractors who meet or exceed certain performance standards. Based on information furnished by CMS, we estimate that the incentive payments would total 3 percent of operating payments to contractors, or about $250 million over the 2004-2008 period.

H.R. 810 would require CMS to competitively bid contracts with fiscal intermediaries and carriers at least every five years. CBO expects that an additional 3-to-5 full-time-equivalent employees (FTEs) at the GS-12 level would be needed throughout the period to write new competitively bid contracts. The estimate assumes that about one-quarter of the contracts would be awarded to a nonincumbent bidder, and that it would cost about $2 million to transition between contractors. CBO estimates that implementing this provision would cost about $66 million over the 2004-2008 period. CBO expects that the competitive bidding of contracts would yield savings to CMS over the long run, but that savings over the 2004-2008 period would probably not be significant.

*New Contractor Activities*. The bill would require contractors to respond to written requests for guidance within 45 days of receipt, and would make that response binding on the Medicare program. We expect that contractors would receive 50 percent more written requests under H.R. 810 than they would under current law, with each request costing $16 dollars to process in 2004. This, plus the requirement that contractors respond to those

requests within 45 days, would require contractors to hire additional employees. CBO estimates that implementing these provisions would cost $11 million in 2004 and $81 million over the 2004-2008 period.

The bill also would require contractors to monitor the accuracy of information given to providers and the timeliness of contractors' processing of providers' enrollment applications. CBO estimates that complying with these provisions would cost about $16 million over the 2004-2008 period.

Beginning in January 2005, the bill would require contractors, upon request of a beneficiary or provider, to make a determination about whether Medicare will cover a particular service or item before that service is furnished. The contractor would be required to conduct a medical review and to make the coverage decision within 45 days. CBO estimates that contractors would make about 100,000 determinations a year at an average cost of about $125 per determination (at 2005 prices). We estimate the cost of administering this program would total $44 million over the 2005-2008 period.

The bill would require contractors to create a system by which providers may resubmit claims originally submitted with errors or omissions without having to pursue payment via the appeals process. CBO estimates the cost of developing and operating systems to process these resubmitted claims would total $5 million in 2004 and $56 million over the 2004-2008 period.

The bill also would require contractors to give providers or beneficiaries, upon request, a summary of the clinical and scientific evidence used in making a determination and in making a redetermination, in the case of an appeal. CBO estimates the cost of making available scientific and clinical evidence on determinations and redeterminations would total $706 million over the 2004-2008 period.

**Appeals Reform.** H.R. 810 would change the processes by which Medicare adjudicates appeals by providers of payment denials and conducts compliance actions against providers. The bill would delay the date by which CMS is required to implement certain provisions of the Beneficiary Improvement and Protection Act and modify other provisions. CBO estimates that implementing these provisions would cost $9 million in 2004 and $94 million over the 2004-2008 period.

*Administrative Law Judge Transfer*. The bill would transfer certain administrative law judges (ALJs) from the Social Security Administration to the Department of Health and Human Services and would permit the Secretary to hire more ALJs. CBO estimates that the costs of planning and implementing the transfer, adding ALJs, and providing the ALJs with

additional training on Medicare issues would be $1 million in 2004 and would total $45 million over the 2004-2008 period.

*Standardization of Compliance and Appeals Actions*. The bill would also standardize existing policies regarding the use of random and non-random prepayment review, the use of extrapolation in the case of overpayments, and the offering of repayment plans in the case of overpayment. In addition, H.R. 810 would create procedures by which appellants may petition for expedited access to judicial review in federal district court in certain circumstances. The bill also would require that judgments by administrative law judges contain the scientific evidence used in their decision, similar to the bill's requirements of contractors. CBO estimates that implementing those provisions would cost $46 million over the 2004-2008 period. These provisions would require CMS to make changes to current appeals and compliance systems but would not change the conditions under which Medicare would make payments to providers. Therefore, CBO estimates that these provisions would have no effect on direct spending.

**Provider and Beneficiary Programs**. H.R. 810 would direct CMS to expand its programs to educate beneficiaries and providers. CBO estimates that implementing these provisions would cost $10 million in 2004 and $171 million during the 2004-2008 period.

The bill would authorize the appropriation of $25 million in 2005 and in 2006, and such sums as necessary in subsequent years, for the education of providers on Medicare billing and coding practices. H.R. 810 would direct the Secretary to conduct a demonstration with small providers and suppliers in which they can get specific help with Medicare policies, including coding and reimbursement. CBO estimates that implementing these provisions would cost $108 million over the 2004-2008 period.

H.R. 810 would require CMS to designate two ombudsmen to act as liaisons between providers and Medicare, and between beneficiaries and Medicare. CBO assumes that, in order to respond to providers' and beneficiaries' needs and complaints, the ombudsmen would require the aid of several staff members. CBO estimates the cost of implementing these provisions would be $59 million over the 2004-2008 period.

The bill would direct CMS to implement a three-year outreach demonstration in at least six locations throughout the United States. The program would involve the deployment of Medicare specialists to local Social Security Administration offices to provide beneficiaries assistance and advice regarding the Medicare program. CBO estimates that the costs of the demonstration, which would include the rental of office space, salaries for Medicare specialists, and travel, moving, and administrative expenses, would total $4 million over the 2004-2008 period.

**Development of Policies, Procedures, and Time Lines**. H.R. 810 would require CMS to develop new policies, procedures, and time lines with regard to the issuance of regulations and documentation guidelines for evaluation and management services. CBO estimates the cost of implementing these provisions would be $9 million in 2004 and $37 million during the 2004-2008 period.

*Final Regulations*. The bill would require CMS to create a time line for publishing final regulations and would limit publication of new regulations to once a month. The estimate assumes there currently are about 20 "interim final rules"; the bill would require CMS to make those rules final, and would require CMS to finalize all future regulations. We estimate that CMS would need to hire an additional 3-to-5 people, at the GS-11 level or higher, to comply with the requirement to finalize all future interim regulations and to produce the required reports. CBO estimates the cost of implementing these provisions would be $9 million in 2004 and $19 million during the 2004-2008 period.

*Documentation Guidelines for Evaluation and Management (E&M) Services*. H.R. 810 would restrict CMS from implementing new documentation guidelines for evaluation and management services until several conditions have been met. Those conditions include:

- Establishing plans to improve the guidelines;
- Completing pilot projects to test modifications to the guidelines;
- Educating providers about the guidelines; and
- Consulting providers during the entire process of testing and establishing the guidelines.

CMS currently has E&M guidelines in place, and the bill would not require changes in those guidelines. CBO assumes that CMS will attempt to update those guidelines during the next few years, because both CMS and provider groups have expressed interest in doing so. The new procedural requirements would increase the cost of developing and implementing new E&M guidelines. Establishing new guidelines for E&M documentation would require the hiring of at least two FTEs for the administration of the pilot projects, for outreach to providers, and for consultation with providers. CBO further estimates that CMS would conduct at least three pilot projects, with each project costing around $1 million per year, and that the studies and reports required by these provisions would cost another $1 million.

**Miscellaneous provisions.** H.R. 810 would require the Secretary, the Comptroller General, and the Office of the Inspector General to conduct several studies, produce reports, and conduct evaluations. In addition, the bill would require the Secretary to establish two groups, a technical group to review issues relating to the Emergency Medical Treatment and

Active Labor Act and a council for technology and innovation to coordinate activities with respect to new medical technologies. CBO estimates that conducting these activities would cost $12 million over the 2004-2008 period.

### Direct Spending

H.R. 810 would change the conditions under which Medicare would pay for services and would create a process to establish whether an item or service is covered prior to a beneficiary receiving the service. CBO estimates that enacting these provisions would have no significant effect on direct spending.

In general, if a provider is not certain whether Medicare will pay for a service or item in a particular case, there is no process under current law that enables the provider or beneficiary to find out in advance whether Medicare will pay for that service or item. In such cases, the provider may request that the beneficiary sign an advanced beneficiary notice (ABN) by which the beneficiary accepts responsibility for paying for the service if Medicare denies payment. (The provider is prohibited from charging the beneficiary if the beneficiary does not sign an ABN and Medicare subsequently denies payment.)

The bill would authorize the Secretary to specify services for which the provider or beneficiary may request a coverage determination before a service is furnished. Upon receipt of such a request, the bill would require the contractor to conduct a medical review and issue a decision within 45 days. The bill would make a positive determination by a contractor binding, but it would limit the number of appeals a provider could make in the event of a negative determination by a contractor.

H.R. 810 directs the Secretary to exclude this provision as a change in law or regulation in the calculation of the sustainable growth rate (SGR) used in the calculation of physician payments under Medicare. (In general, changes in law and regulation are incorporated into the calculation of the SGR). The SGR is a self-correcting mechanism: any additional services paid for under this provision would be offset by lower physician payments in subsequent years. CBO therefore estimates that enacting this provision could affect direct spending in each year, but would not have a significant impact over the 2004-2013 period.

## INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 810 would expand an existing intergovernmental and private-sector mandate, as defined by UMRA, but CBO cannot estimate whether any new costs of complying with the mandate would exceed the thresholds established by UMRA. (In 2003, the thresholds are $59 million

for intergovernmental mandates and $117 million for private-sector mandates. The thresholds are adjusted annually for inflation.)

**Intergovernmental and Private-Sector Mandates**

Current law directs the Secretary of HHS to establish standards for collecting and reporting health data under the Health Insurance Portability and Accountability Act. As a result, public and private health plans, health care clearinghouses, and health care providers must use the coding systems authorized by the Secretary when they record and exchange health care information. The law also requires the Secretary to rely on the recommendations of the National Committee on Vital and Health Statistics when establishing those coding standards. H.R. 810 would allow the Secretary to establish a new coding system (the International Classification of Diseases, 10th Revision: ICD-10) in the absence of an explicit recommendation from the NCVHS to move to that new system.

This expanded authority could increase the cost of the existing mandate on public and private health plans and providers regarding the coding system they must use. It is unclear, however, whether the Secretary would actually require the implementation of the ICD-10 in the absence of a recommendation from the NCVHS, and it is also unclear whether the NCVHS will recommend a new system in the near future under current law. As a result, CBO does not have a basis for determining whether the affected entities would face additional costs, or if they did, whether those increased costs would exceed the intergovernmental and private-sector thresholds specified in UMRA ($59 million and $117 million, respectively, in 2003, adjusted annually for inflation). Information about the potential effects of such a change are limited. However, HHS is conducting a study of the costs of moving to the ICD-10 system, as well as the savings that plans and providers would obtain by operating under the new, more efficient system. HHS expects to release the findings of that study late in the summer of 2003.

**Other Impacts on State, Local, and Tribal Governments**

Although not an intergovernmental mandate as defined by UMRA, the requirement for public hospitals that participate in the Medicare program to comply with the OSHA bloodborne pathogens standard would have cost implications for state and local governments. The current OSHA standard applies to all private-sector employers with one or more employees, as well as federal civilian employees. This bill would extend the requirement to all hospitals participating in the Medicare program, including state and local public hospitals. About half of the states currently have bloodborne pathogen standards that apply to these hospitals that are at least as stringent as the federal standard, and many other hospitals have voluntarily established comparable standards. Consequently, CBO does not expect the costs of the

requirement to be significant, and any such costs would result from participating in a voluntary federal program and thus would not be costs of an intergovernmental mandate as defined in UMRA.

**ESTIMATE PREPARED BY:**

Federal Costs: Alexis Ahlstrom
Impact on State, Local, and Tribal Governments: Leo Lex
Impact on the Private Sector: Robert Nguyen

**ESTIMATE APPROVED BY:**

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis