CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 3, 2016

H.R. 5273
Helping Hospitals Improve Patient Care Act of 2016

As ordered reported by the House Committee on Ways and Means on May, 24 2016

SUMMARY

H.R. 5273 would modify Medicare payment rules for certain hospital outpatient departments and some hospital inpatient services, increase the number of beds for long-term care hospitals (LTCHs), extend a demonstration involving rural community hospitals, modify meaningful use standards for some physicians practicing in ambulatory surgical centers, and delay the Center for Medicare and Medicaid Services' (CMS) authority to terminate certain Medicare Advantage (MA) contracts.

CBO estimates that enacting H.R. 5273 would increase direct spending by $50 million over the 2017-2021 period but decrease direct spending by $14 million over the 2017-2026 period. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. Enacting the bill would not affect revenues.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

H.R. 5273 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of H.R. 5273 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By Fiscal Year, in Millions of Dollars											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
INCREASES OR DECREASES (-) IN DIRECT SPENDING[a,b]												
TITLE I—PROVISIONS RELATING TO MEDICARE PART A												
Rural hospital demonstration	26	102	-29	-77	0	0	-6	-19	-17	0	22	-21
Long-term care hospitals	-1	5	10	0	-2	-2	-2	-2	-3	-3	12	0
IPPS update	0	-55	-70	-75	-80	-85	-90	-90	-100	-105	-280	-750
TITLE II—PROVISIONS RELATING TO MEDICARE PART B												
Payment rules for off-campus outpatient departments	20	50	60	70	80	90	90	90	100	110	280	760
Payment rules for off-campus outpatient departments of cancer hospitals	5	5	5	5	0	0	-5	-5	-5	-5	20	0
Electronic health records in ambulatory surgical centers	4	9	4	0	0	0	0	0	0	0	17	17
TITLE III—OTHER MEDICARE PROVISIONS												
Delay termination for Medicare Advantage plans	0	-5	-10	-5	0	0	0	0	0	0	-20	-20
Total, Net Increases or Decreases (-) in Direct Spending Outlays	**54**	**111**	**-30**	**-82**	**-2**	**3**	**-13**	**-27**	**-25**	**-3**	**50**	**-14**
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM INCREASES OR DECREASES (-) IN DIRECT SPENDING												
Impact on Deficit	**54**	**111**	**-30**	**-82**	**-2**	**3**	**-13**	**-27**	**-25**	**-3**	**50**	**-14**

Notes: Components may not add to totals because of rounding.
IPPS = inpatient prospective payment system; TRICARE = the health plan operated by the Department of Defense.

a. Budget authority equals outlays for direct spending provisions. All changes in direct spending are on-budget.

b. All Medicare provisions include interactions with Medicare Advantage payments, Medicare Part A and Part B premiums, and TRICARE.

BASIS OF ESTIMATE

Title I. Provisions Affecting Medicare Part A

Rural hospital demonstration. Section 103 of the bill would extend the Rural Community Hospital Demonstration Program for an additional five years and allow more hospitals to enter the demonstration. Under the demonstration program, Medicare pays certain hospitals in rural areas on the basis of the reasonable costs they incur instead of using the payment rates determined by Medicare's Inpatient Prospective Payment System (IPPS). CBO estimates that enacting this provision would increase direct spending in fiscal years 2017 and 2018. However, when the cost reports for those years are settled (generally

five years after the fiscal year ends), the Medicare program would recoup those increases in payments by reducing the payment rates for all hospitals paid under the IPPS. Those changes in payments to hospitals also would affect payment rates for Medicare Advantage plans, which are based on spending in the fee-for-service part of Medicare. CBO estimates that the initial increases in payments to MA plans would be smaller than the subsequent reductions (when the hospitals' cost reports are settled) because the share of Medicare beneficiaries enrolled in MA is projected to increase over the next ten years. In total, CBO estimates that section 103 would reduce direct spending for Medicare by $21 million over the 2017-2026 period.

Long-term care hospitals. Title I would lift a moratorium in current law that prohibits existing long-term care hospitals (LTCHs) from increasing the number of beds in their facilities. CBO estimates that provision would increase payments to LTCHs by about $20 million over the 2017-2026 period. To offset that increase, payment rates for LTCH services would be reduced by 0.08 percent beginning in 2017. In combination, CBO estimates those provisions would have no net budgetary effect over the 2017-2026 period.

IPPS update. The bill would reduce the update to IPPS payment rates for services furnished in fiscal year 2018 by 0.04 percentage points. CBO estimates that provision would reduce direct spending for Medicare by $750 million over the 2017-2026 period.

Other provisions. Title I also would require the Secretary of Health and Human Services to develop a mechanism that would enable services provided in an outpatient department to be assigned to the diagnosis-related groups that are used to set payment rates for hospital inpatient services. In addition, Title I would require the Secretary to modify the criteria for determining which hospitals are subject to payment reductions related to high readmission rates. CBO estimates those provisions would have no budgetary effect.

Title II. Provisions Affecting Medicare Part B

Payment rules for off-campus outpatient departments. Section 201 would exempt certain hospital outpatient departments (HOPDs) from payment rules established in the Bipartisan Budget Act of 2015 (BBA15). Those payment rules require Medicare to pay for services furnished in new off-campus facilities using the payment rates that would have been in effect if the services were performed in an office setting or an ambulatory surgical center beginning in 2018.[1]

1. In Medicare, payment rates for the same service vary based on the setting. Services provided in an office setting by physicians and health professionals are paid a single fee from the physician fee schedule (PFS). For services provided in facilities, such as HOPD or ambulatory surgical centers, Medicare pays the practitioner a fee from the PFS, which is lower than the comparable fee in the professional's office, and a facility fee to either the HOPD or ASC. Generally, the total payment rate for services provided in facilities is higher than the rate for the same service provided in an office.

Off-campus facilities that were already billing as HOPDs when BBA15 was enacted continue to receive the higher payment rates that apply to an outpatient department on the campus of a hospital. H.R. 5273 would allow off-campus facilities that were under construction on November 2, 2015, to be paid at the same rates as an HOPD beginning in 2018. H.R. 5273 would require such facilities to document and attest that status, and the Secretary of Health and Human Services would be required to conduct audits during 2017 and 2018.

Nearly 100 hospitals have identified themselves as having off-campus facilities under construction on November 2, 2015. Based on that information, CBO estimates that increasing payment rates for services provided in those facilities would increase net Medicare spending by $750 million over the 2017-2026 period. H.R. 5273 would also provide an additional $10 million in funding for implementing section 201.

Payment rules for off-campus outpatient departments of cancer hospitals. Section 202 would exclude new off-campus facilities in cancer hospitals that are exempt from Medicare's prospective payment system from the lower payment rates established in BBA15. Payment rates for services in these new off-campus facilities would continue under the rules in place prior to enactment of BBA15 and would generally be higher. Those facilities would have to attest that they qualify for those higher payment rates and the Secretary would be required to audit that attestation. The bill would provide $2 million for those audits. In addition, section 202 would apply an across-the-board 1 percent reduction to payment rates for services furnished by outpatient departments of cancer hospitals in 2018. Taken together, CBO estimates the provisions of section 202 would increase direct spending by $20 million over the 2017-2021 period, but would have no net budgetary effect over the 2017-2026 period.

Electronic health records in ambulatory surgical centers. Section 203 of H.R 5273 would exempt eligible professionals based in an ambulatory surgical center (ASC) from being subject to payment reductions for failing to meet the requirements for meaningful use of electronic health records (EHRs) that were established by the Health Information Technology Act of 2009. That exemption would apply to payments made in calendar years 2017 and 2018 and would continue under the Merit-Based Incentive Payment System (MIPS) starting in 2019. The exemption would expire three years after the Secretary determines that certified EHR technology applicable to ASCs is available.

Very few ASCs currently have EHR technology. Thus, section 203 would enable about 2,000 ASC-based professionals to avoid penalties related to their use of EHR. Under current law, CBO expects those penalties to average about $3,000 for each professional in calendar years 2017 and 2018. Beginning in 2019 under the MIPS program, any change in Medicare payments to professionals based in ASCs would be offset by changes in payment rates to other professionals. CBO estimates that section 203 would result in fewer penalties, which would increase direct spending by $17 million over the 2017-2026 period.

Title III. Other Medicare Provisions

Delay termination for Medicare Advantage plans. Under current law, the Centers for Medicare and Medicaid Services (CMS) has announced that, beginning with plan year 2017, it will not renew contracts with Medicare Advantage plans that fail, for three consecutive years, to achieve at least three stars under the five-star quality-rating system. The bill would delay CMS' authority to terminate those contracts until plan year 2020. Thus, enacting the legislation would permit certain plans that otherwise would not be renewed under current law to continue operating through 2019. Those plans tend to receive slightly lower payments than other Medicare Advantage plans in the same areas, in part because they do not receive bonus payments under the five-star rating system.

CBO projects that very few beneficiaries—less than 0.1 percent of MA enrollees—will be enrolled in plans that fail to achieve minimum quality ratings, and thus would be subject to the changes under the legislation. Permitting those plans to continue operating would reduce direct spending by $20 million over the 2017-2026 period, CBO estimates.

CMS has announced that one contract will not be eligible for renewal in 2017. Although H.R. 5273 would make that contract eligible for renewal, CBO assumes that the legislation would be enacted towards the end of fiscal year 2016, after the point when insurance carriers must submit materials in order to participate in the program in 2017. Thus, in CBO's judgment, the legislation would have no effect on spending or on the number of plans that will participate in the MA program during that year.

Other provisions. H.R. 5273 would require CMS to publish data on enrollment in the fee-for-service and Medicare Advantage components of the Medicare program at the state and Congressional-district level and provide clear descriptions of the fee-for-service, Medicare Advantage, and Part D prescription drug programs in the "Welcome to Medicare" package that is given to new enrollees. CBO estimates those provisions would not affect direct spending because neither would affect Medicare's coverage rules or payment rates.

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. 5273, as ordered reported by the House Committee on Ways and Means on May 24, 2016

	By Fiscal Year, in Millions of Dollars												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-2021	2016-2026
NET INCREASE OR DECREASE (-) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	54	111	-30	-82	-2	3	-13	-27	-25	-3	50	-14

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 5273 contains no intergovernmental or private-sector mandates as defined in UMRA, and would not affect the budgets of state, local, or tribal governments.

PREVIOUS CBO ESTIMATE

On July 17, 2015 CBO transmitted a cost estimate for S. 607, the Rural Community Hospital Demonstration Extension Act of 2015 as reported by the Senate Committee on Finance on June 24, 2015. Section 103 of H.R. 5273 is similar to S. 607. Differences in the estimated budgetary effects of the two bills reflect the fact that section 103 of H.R. 5273 would allow additional hospitals to join the Rural Community Hospital demonstration.

On June 15, 2015 CBO transmitted a cost estimate for H.R. 2580, the LTCH Technical Correction Act of 2015 as reported by the House Committee on Ways and Means on June 2, 2015. Section 104 of H.R. 5273 is similar to H.R. 2580. Changes in the budgetary effects of the two bills reflect changes in CBO's baseline projections under current law.

CBO has published two previous estimates of bills similar to provisions in section 203, which would modify the treatment of eligible professionals in ambulatory surgical centers for meaningful use and MIPS. CBO transmitted a cost estimate for H.R. 887 on March 12, 2015, and an estimate for S. 1347 on July 16, 2015; those two bills had identical language and were both entitled the Electronic Health Fairness Act of 2015. Differences in

the estimated budgetary effects in section 203 from those previous estimates reflect differences in the legislative language.

On June 12, 2015, CBO transmitted a cost estimate for H.R. 2506, the Seniors' Health Care Plan Protection Act of 2015, as reported by the House Committee on Ways and Means on June 2, 2015. Section 301 of H.R. 5273 is similar to H.R. 2506. Differences in the estimated budgetary effects of the two bills reflect updated information on plan performance in the star-ratings system.

ESTIMATE PREPARED BY:

Federal Costs: Lori Housman, Jamease Kowalczyk, Paul Masi, Kevin McNellis, and Zoë Williams
Impact on State, Local, and Tribal Governments: Zachary Byrum
Impact on the Private Sector: Amy Petz

ESTIMATE APPROVED BY:

Holly Harvey
Deputy Assistant Director for Budget Analysis