CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 25, 2016

H.R. 5713
Sustaining Healthcare Integrity and Fair Treatment Act of 2016

As ordered reported by the House Committee on Ways and Means on July 13, 2016

SUMMARY

H.R. 5713 would modify Medicare's payments to Long-Term Care Hospitals (LTCHs) and would prohibit Medicare from paying for items or services furnished by certain newly enrolled providers in select areas of the country. CBO estimates that enacting the bill would, on net, increase direct spending by $25 million over the 2017-2021 period but would have no net effect 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 in any of the four consecutive 10-year periods beginning in 2027.

H.R. 5713 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. 5713 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 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												
Long-Term Care Hospitals	38	5	2	0	0	0	0	0	0	0	45	45
Moratorium On Certain New Providers	0	-5	-5	-5	-5	-5	-5	-5	-5	-5	-20	-45
Total Changes	38	0	-3	-5	-5	-5	-5	-5	-5	-5	25	0

BASIS OF ESTIMATE

CBO estimates that the changes in payment rules for LTCHs would increase spending by $45 million over the 2017-2026 period, while expanding the moratorium would reduce spending by the same amount over that time period.

Long-Term Care Hospitals

Under current law, certain hospitals that treat patients considered to be medically complex with an average length of stay that exceeds 25 days are designated as LTCHs. Medicare payments for care provided in LTCHs are either made at rates determined in the prospective payment system for LTCHs, or at a so-called "site-neutral" rate. Through 2017, the site-neutral rate is a blend of the LTCH rates and the substantially lower rates that would be paid under the inpatient prospective payment system (IPPS). Beginning in 2018 all payments will be at the IPPS payment rate. Generally, discharges that involve specific conditions for patients with a stay of at least three days in an intensive care unit before being admitted to the LTCH are paid based on the LTCH system. Other discharges are paid at the site-neutral rate. Beginning on July 1, 2016, if more than 25 percent of Medicare patients in an LTCH are admitted from a single hospital, the site-neutral payment rate will be applied to all cases admitted from that hospital in excess of that 25 percent threshold.

Title I of H.R 5713 would suspend the application of site-neutral payments for cases that exceed that 25 percent threshold between October 1, 2016 and June 30, 2017. It also would exempt inpatient services furnished to Medicare beneficiaries who are treated during:

- Fiscal years 2018 and 2019 for certain conditions, including spinal and traumatic brain injuries, that are treated at not-for-profit LTCHs that specialize in the treatment of those conditions, and

- Fiscal year 2018 for certain kinds of severe wounds.

Based on analysis of administrative data, CBO estimates that enacting those changes to payment rates for Medicare patients treated in LTCHs would increase direct spending by $45 million over the 2017-2026 period.

Moratorium On Certain New Providers

Under current law, the Secretary of Health and Human Services (HHS) may temporarily prevent individuals and firms from enrolling to furnish services in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) if the prohibition would reduce the occurrence of fraud, waste, and abuse. The authority is specific to certain geographic areas and, since it became available, the Secretary has imposed temporary moratoria for home health providers in six metropolitan areas and for ambulance providers in two metropolitan areas.

Title II would prohibit newly enrolled providers and suppliers located outside an area with such a moratorium from billing for services provided within a region covered by a moratorium. CBO expects that the legislation would prevent providers and suppliers from evading the intent of the moratorium in certain areas. New providers and suppliers could still furnish and bill for services provided outside the moratorium zone.

Because enacting that provision would slightly reduce the number of services for which Medicare, Medicaid, and CHIP would pay, CBO estimates that enacting the provision would reduce direct spending for those programs by about $45 million over the 2017-2026 period. About three-quarters of that effect (or $34 million) would come from reduced spending in Medicare and the remainder (about $11 million) would be attributable to Medicaid and CHIP.

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. 5713, as ordered reported by the House Committee on Ways and Means on July 13, 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	38	0	-3	-5	-5	-5	-5	-5	-5	-5	25	0

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

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

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 5713 contains no intergovernmental or private-sector mandates as defined in UMRA. The bill's limits on Medicaid and CHIP payments to the providers that bill for services within moratorium areas would result in reduced spending by states for those programs of about $8 million over the 2017-2026 period.

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