CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 22, 2008

H.R. 5613
Protecting the Medicaid Safety Net Act of 2008

As ordered reported by the House Committee on Energy and Commerce on April 16, 2008

SUMMARY

H.R. 5613 would extend existing moratoria on certain regulatory actions taken by the Centers for Medicare & Medicaid Services (CMS) with regard to the Medicaid program. Those actions are related to payments for services furnished by public providers, for graduate medical education, for school-based administration and transportation services, and for rehabilitation services. In addition, the bill would impose new moratoria on Medicaid regulations involving targeted case-management services and provider taxes and on a proposed regulation involving outpatient hospital services. The bill would appropriate $5 million to study the effects of these regulations on the Medicaid program.

The bill would make additional changes to Medicaid by requiring more stringent verification of assets in certain eligibility determinations. H.R. 5613 also would appropriate $25 million a year to the Secretary of Health and Human Services to address fraud and abuse in Medicaid and would reduce funding for the Medicare physician assistance and quality initiative (PAQI) fund in fiscal year 2013, and increase such funding in 2014.

Some of the bill's provisions would increase direct spending; others would reduce direct spending. CBO estimates that the increases would amount to $1.8 billion over the 2008-2013 period and $1.9 billion over the 2008-2018 period, largely due to the required delays in implementing regulations. Other provisions related to asset verification and adjustments to the PAQI fund would reduce direct spending by similar amounts. On net, H.R. 5613 would reduce direct spending by $3 million over the 2008-2013 and 2008-2018 periods.

H.R. 5613 would not affect federal revenues or discretionary spending. This 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 H.R. 5613 is shown in the following table. The changes in direct spending fall within budget functions 550 (health) and 570 (Medicare).

	By Fiscal Year, in Millions of Dollars												
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2008-2013	2008-2018
CHANGES IN DIRECT SPENDING													
Moratoria on Certain Medicaid Regulations													
Estimated Budget Authority	445	1,205	0	0	0	0	0	0	0	0	0	1,650	1,650
Estimated Outlays	445	1,205	0	0	0	0	0	0	0	0	0	1,650	1,650
Funds to Reduce Fraud and Abuse													
Estimated Budget Authority	0	25	25	25	25	25	25	25	25	25	25	125	250
Estimated Outlays	0	24	25	25	25	25	25	25	25	25	25	124	249
Study on Impact of Regulations													
Estimated Budget Authority	5	0	0	0	0	0	0	0	0	0	0	5	5
Estimated Outlays	0	5	0	0	0	0	0	0	0	0	0	5	5
Medicaid Asset Verification													
Estimated Budget Authority	0	-80	-130	-180	-230	-380	-490	-590	-690	-820	-950	-1,000	-4,540
Estimated Outlays	0	-80	-130	-180	-230	-380	-490	-590	-690	-820	-950	-1,000	-4,540
Medicare Physician Assistance and Quality Fund													
Estimated Budget Authority	0	0	0	0	0	-1,203	3,777	58	0	0	0	-1,203	2,633
Estimated Outlays	0	0	0	0	0	-782	2,027	1,387	0	0	0	-782	2,633
Total Changes													
Estimated Budget Authority	450	1,150	-105	-155	-205	-1,558	3,312	-507	-665	-795	-925	-423	-2
Estimated Outlays	445	1,154	-105	-155	-205	-1,137	1,562	822	-665	-795	-925	-3	-3

Note: Components may not sum to totals because of rounding.

BASIS OF ESTIMATE

The bill contains provisions that would both increase and decrease direct spending. CBO estimates that the net impact would be savings of $3 million over both the 2008-2013 period and over the 2008-2018 period. This estimate assumes that the bill will be enacted by late in May 2008.

Moratoria on Certain Medicaid Regulations

CMS has taken regulatory action to limit payments under the Medicaid program for certain financing mechanisms and services. The Congress previously enacted moratoria on four of those regulations. H.R. 5613 would extend the existing moratoria through April 1, 2009, and would impose new moratoria through April 1, 2009, on certain provisions of regulations involving targeted case-management services, provider taxes, and covered outpatient services. In total, CBO estimates that the seven moratoria would increase Medicaid spending by $1.7 billion over the 2008-2009 period.

All of the regulations addressed by H.R. 5613 are incorporated either fully or partially in CBO's baseline projections of Medicaid spending. For final regulations, CBO fully incorporates the projected effects into the baseline (after any moratorium ends), reflecting implementation of current law. For proposed rules or other significant administrative actions, CBO generally assigns a weight of 50 percent in its baseline, reflecting the uncertainties of the administrative process.

Payment to Public Providers. CMS issued a final rule on May 29, 2007, to restrict the use of intergovernmental transfers and limit payment to public providers to cost (public providers are health care providers owned or operated by a unit of government). The final rule:

- Clarifies that the only providers that may participate in providing the nonfederal share of Medicaid funding are those that are part of a unit of government;

- Limits Medicaid payments to cost for providers operated by units of government; and

- Requires that providers retain the full amount of their Medicaid payments.

The Congress enacted a moratorium on implementation of that rule that will remain in effect until May 25, 2008, under current law. Using information from CMS on how states use intergovernmental transfers, estimates of hospital and nursing home spending based on administrative data, and analysis of the distribution of spending by facility ownership, CBO estimates the bill's extended moratorium on the public provider final rule would increase spending by a total of $0.8 billion in fiscal years 2008 and 2009.

Graduate Medical Education. On May 23, 2007, CMS issued a proposed rule to prohibit payment for Medicaid graduate medical education. The Congress enacted a moratorium on further regulatory action in this area, which remains in effect until May 25, 2008. The extension of that moratorium on the proposed rule for graduate medical education would increase spending by $0.1 billion over the 2008-2009 period, CBO estimates, based on information from CMS about which states use Medicaid funds for graduate medical

education. Because the graduate medical education regulation is proposed and not final, CBO's estimate represents half of the potential costs of this moratorium.

School-based Administration and Transportation Services. On December 20, 2007, CMS issued a final rule prohibiting payments for administrative costs for any activities performed by employees or contractors of local school districts and for transportation of Medicaid recipients from their home to their school. The Congress enacted a moratorium on implementing that rule, which will remain in effect until May 25, 2008. Relying on spending information provided by CMS, CBO estimates that extending this moratorium would increase spending by at total of $0.5 billion in fiscal years 2008 and 2009.

Rehabilitation Services. On August 13, 2007, CMS issued a proposed rule to narrow the definition of rehabilitation services. The proposed rule would:

- Prohibit payments for services that are "intrinsic parts" of other programs such as foster care, child welfare, or juvenile justice;

- Ban states from using bundled rates to pay for therapeutic foster care (which is a type of rehabilitation service);

- Prohibit payments, unless otherwise permitted by a Secretarial waiver, for habilitation services (which help individuals to develop new skills instead of restoring previously existing skills); and

- Restrict payments for recreational or social services.

The Congress enacted a moratorium on further agency action in this area, which remains in effect until May 25, 2008. The bill's extended moratorium on implementing the rehabilitation rule would increase spending by $0.1 billion over the 2008-2009 period. Because the rehabilitative services regulation is proposed and not final, CBO's estimate represents half of the potential costs of this moratorium.

Targeted Case Management. The Deficit Reduction Act of 2005 clarified and narrowed payment policy for targeted case-management services, and required CMS to issue a final rule to implement the policy. On December 4, 2007, CMS issued a final rule, which went into effect on March 3, 2008. The rule defines case-management and targeted case-management services and clarifies that those services may not include the direct delivery of other social services, specifically foster care. It also limits transitional assistance services to individuals in institutions to 60 days (as opposed to 180 days), restricts services to only one case manager per person, requires that payments be based on 15-minute

increments, and prohibits child welfare agencies and contractors from serving as case managers.

The bill would not prevent CMS from implementing the clarification of targeted case management outlined in the Deficit Reduction Act of 2005. However it would prohibit implementation of portions of the rule that are more stringent than the statute, particularly the restriction on days of service and the limit of one case manager per person. The moratorium on implementing the portion of the targeted case management final rule that is more stringent than the underlying statute would increase spending by a total of $0.1 billion in fiscal years 2008 and 2009, CBO estimates. CBO based its analysis of this rule on projections of expenditures for targeted case management by state, using administrative spending and enrollment data, and analysis of the regulation by the Kaiser Family Foundation.

Provider Taxes. On February 22, 2008, CMS issued a final rule that revises standards on permissible provider taxes through 2011, lowering allowable amounts from 6.0 percent to 5.5 percent of gross patient revenues. The final rule specifies methodologies for determining when states are using an impermissible tax. H.R. 5613 would allow the provider tax limits to go into effect, but would delay implementation of the clarifications outlined in the regulation. CBO estimates this delay would have no effect because the regulation codifies current practices, which would continue in the absence of that regulation.

Outpatient Clinic and Hospital Services. On September 28, 2007, CMS issued a proposed rule to clarify the definition of outpatient clinic and hospital services eligible for payment under the Medicaid program and to require states to use the definition of "outpatient hospital services" that is used by Medicare.

Based on Medicaid administrative spending data, information from CMS, and analysis of the regulation by the Kaiser Family Foundation, CBO expects that the moratorium on the proposed rule clarifying outpatient clinic and hospital services would allow certain services to be performed in higher-cost settings and estimates that a delay in implementation would increase spending by a total of $0.1 billion in fiscal years 2008 and 2009. Because the regulation is proposed and not final, CBO's estimate represents half of the potential costs.

Funds to Reduce Fraud and Abuse

H.R. 5613 would appropriate $25 million a year for the Secretary of Health and Human Services to address fraud and abuse in the Medicaid program. CBO estimates that this provision would cost about $125 million and $250 million over the 2009-2013 and 2009-2018 periods, respectively.

Study on Impact of Medicaid Regulations

The bill would appropriate $5 million for the Secretary of Health and Human Services to contract with an independent organization to produce a report on the impact of the regulations subject to the moratoria and an analysis of the problems the regulations were designed to address. CBO anticipates those funds would be spent in fiscal year 2009.

Medicaid Asset Verification Demonstration

Section 5 would require all states to incorporate into their Medicaid programs a demonstration program from the Supplemental Security Income (SSI) program. The program uses Web-based techniques to identify assets that might otherwise not be discovered through the eligibility-determination process and requires beneficiaries to allow access to their financial information. Under current law, New York and New Jersey, which both operate the SSI demonstration, are required to implement this program for Medicaid through 2013. The bill would allow a five-year phase-in period during which CMS would develop a staggered schedule for states to adopt the necessary administrative and systems requirements. California, which recently implemented the SSI demonstration, would be required to implement the program for Medicaid by the end of fiscal year 2009. The bill would permit states to enroll people in the demonstration program even if they refuse to allow disclosure of their financial information.

Based on information from CMS, CBO expects that the new Medicaid procedures would result in denial of or delay in eligibility for some people and reduced enrollment in Medicaid, mainly for individuals seeking nursing home coverage or other high-cost long-term care services. CBO estimates that this provision would reduce federal outlays by $1.0 billion over the 2009-2013 period and $4.5 billion over the 2009-2018 period.

Medicare Physician Assistance and Quality Initiative Fund

Under current law, the Secretary of Health and Human Services has $5.0 billion available in 2013 to use for initiatives related to physician payments and quality improvements in Medicare. Section 6 would reduce the funding available in 2013 by $1.2 billion and would increase the funding for 2014 by $3.8 billion. CBO estimates that those changes in funding would decrease outlays by $0.8 billion in 2013 and would increase outlays by $2.6 billion over the 2013-2015 period.

INTERGOVERMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 5613 contains no intergovernmental or private-sector mandates as defined in UMRA. The bill would impose a new requirement on states to electronically verify the assets of Medicaid enrollees. That requirement would increase administrative spending by states; however, the provision also would result in lower caseloads and an overall decline in state spending. Because Medicaid provides states with significant flexibility to make programmatic adjustments to accommodate changes, the requirement to verify assets would not be an intergovernmental mandate as defined by UMRA. State, local, and tribal governments would benefit from provisions in the bill that would delay the implementation of several Medicaid regulations.

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