CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

February 16, 2016

S. 2368
Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015

As reported by the Senate Committee on Finance on December 8, 2015

SUMMARY

S. 2368 would appropriate additional funding for the Office of Medicare Hearings and Appeals (OMHA) and the Departmental Appeals Board (DAB) within the Department of Health and Human Services (HHS). The bill also would modify the hearings and appeals process for Medicare beneficiaries and health-care providers who challenge coverage and payment decisions within that program.

CBO estimates that enacting S. 2368 would increase direct spending by about $1.7 billion over the 2016-2026 period. In addition, implementing the bill would cost approximately $35 million over that same period, assuming appropriation of the necessary amounts. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. The legislation 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.

S. 2368 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 effect of S. 2368 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare). For this estimate, CBO assumes that S. 2368 will be enacted near the end of fiscal year 2016.

	By Fiscal Year, in Millions of Dollars												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-2021	2016-2026
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority	0	213	243	243	243	133	133	133	133	133	133	1,075	1,740
Estimated Outlays	0	205	240	243	243	133	133	133	133	133	133	1,065	1,729
CHANGES IN SPENDING SUBJECT TO APPROPRIATION													
Estimated Authorization Level	0	12	7	2	2	2	2	2	2	2	2	25	35
Estimated Outlays	0	11	7	3	2	2	2	2	2	2	2	25	35

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

BASIS OF ESTIMATE

Background

Medicare beneficiaries and providers of health services (including physicians and hospitals) may appeal adverse coverage and payment decisions. Within the fee-for-service Medicare program, the appeals process has five steps:

- The first step is review by a Medicare Administrative Contractor (MAC), a private entity that processes Medicare claims.
- If the beneficiary or provider wishes to proceed, a Qualified Independent Contractor (QICs) reviews the matter. A QIC is a private entity that has not previously been involved in the disputed issue.
- After the QIC review, an Administrative Law Judge (ALJ) may hear the issue. OMHA oversees the ALJs and administers the hearing process.
- After the ALJ stage, appeals may proceed to the Medicare Appeals Council, which is part of the DAB. The DAB is responsible for adjudicating disputes in numerous programs within HHS.

- The final step is review by the United States District Court for the geographic area in which the beneficiary or supplier is located.[1]

The appeals process for Part C (Medicare Advantage) and Part D (the outpatient drug benefit) differs in the initial stages, but is the same from the ALJ level forward.

Over the past few years, the number of appeals has been rising. For example, OMHA's workload has increased 545 percent between FY 2011 and FY 2013.[2] The rise in the number of appeals has slowed the process: according to OMHA, there is currently a delay of about five months in entering new appeals cases into the ALJ docket and the average processing time for appeals decided in fiscal year 2015 was almost 550 days.[3]

Direct Spending

The bill would affect direct spending in three ways it would: provide almost $1.3 billion for hearing and appeal activities; hasten the resolution of appeals; and reduce recoveries to the Medicare program that result from certain audits.

Section 2 of S. 2368 would appropriate $127 million annually for hearing and appeals activities: $125 million to the Office of Medicare Hearings and Appeals (OMHA) and $2 million to the Departmental Appeals Board (DAB), which administers the Medicare Appeals Council. Based on historical spending patterns, CBO estimates that provision would increase direct spending by about $1.3 billion over the 2016-2026 period.

In addition to appropriating new funding for OMHA and the DAB, S. 2368 would modify the appeals process in several ways. The bill would:

- Mandate the creation of Medicare magistrates to undertake duties similar to those now performed by ALJs;

- Impose monetary thresholds for appeals, so that, for example, Medicare magistrates could not hear cases unless the amount in dispute was at least $150 and ALJ review would be available if the amount in dispute was at least $1,500;

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1. For an overview of the Medicare fee-for-service appeals process, see "Medicare Parts A and B Appeals Process," Department of Health and Human Services, Center for Medicare and Medicaid Services, February 2015. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicareappealsprocess.pdf

2. Testimony of Nancy L. Griswold, Chief Administrative Law Judge, before the Senate Committee on Finance, April 28, 2015. http://www.finance.senate.gov/imo/media/doc/SFC%20Griswold-OMHA%20updated%20testimony%20%204%2028%2015.pdf

3. http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html

- Require that appeals be returned to a prior level (e.g., from the ALJ to the QIC) if new evidence was introduced by a party other than a beneficiary;

- Mandate the development of an expedited appeals process;

- Allow the consolidation of multiple appeals cases related to similar issues or individuals;

- Direct the Secretary of HHS to establish a process through which OMHA and the DAB would refer cases with credible evidence of fraud to law enforcement;

- Require the Secretary to study the feasibility of participation by the Centers for Medicare and Medicaid Services (CMS), QICs, MACs, and other relevant entities in hearings before ALJs; and

- Institute new annual training for ALJs and Medicare magistrates.

CBO estimates that those changes would alter the timing of the appeals and settlement process—accelerating some appeals and slowing others. CBO estimates that the net effect would be to increase direct spending for Medicare benefits by about $460 million because some payments would occur during the 2017-2026 period that are expected to occur after 2026 under current law. CBO expects that most of the effect of that spending would be realized during the 2017-2020 period, as the current appeals backlog is reduced, but spending would increase in each year of the budget window.

S. 2368 would also modify the operations of Recovery Audit Contractors (RACs), which analyze provider claims to look for evidence of over- and under-payment. In recent years, many RAC audits have focused on whether hospitals appropriately bill for beneficiary stays—in particular, whether Medicare is paying the inpatient rate for visits that should have been billed as outpatient, or vice versa. With respect to those patient status audits, S. 2368 would limit the period of time during which RACs could request additional documentation from providers to not more than six months after the date the service was provided. In CBO's judgment, this provision of S. 2368 would codify current practice and thus would have no budgetary impact.

Apart from the hospital claims described above, RACs generally may analyze claims paid during the current fiscal year or during the prior four fiscal years. S. 2368 would grant the Secretary authority to shorten the RAC review period to not more than three years before the current fiscal year. Shortening the review period would prevent some audits that would lead to the recovery of overpayments. Based on the assumption that there is a 50 percent probability that the Secretary would reduce the period subject to review, CBO estimates that the provision would increase direct spending by about $10 million during the 2016-2026 period.

Spending Subject to Appropriation

In addition to the funding authorized and appropriated to OMHA and DAB, S. 2368 would direct CMS and the Government Accountability Office (GAO) to undertake new activities that would not be covered by that funding. Specifically the bill would require development of an Internet portal for providers; creation of an ombudsman for providers; and generation of several reports. CBO estimates that implementing those aspects of S. 2386 would cost about $35 million over the 2016-2026 period, subject to the availability of appropriated funds.

The bill would require CMS to create an Internet portal through which providers could monitor the status of claims that are in the appeals process. Based on the costs of similar CMS activities, CBO estimates that creating such a portal would cost about $5 million in each of fiscal years 2017 and 2018 to set up the portal, and about $500,000 each year thereafter for maintenance. Estimated outlays for implementing this provision would be about $13 million over the 2016-2026 period.

S. 2368 would also require the Secretary to establish an ombudsman to assist providers, suppliers, and Medicare contractors in resolving complaints or other issues. The duties of the Medicare Provider and Supplier Ombudsman would include investigating and resolving inquiries regarding the Medicare review and appeals process, as well as providing recommendations to the Secretary for improvements to that process and assisting in education and training for providers and suppliers. CBO expects that new office would require funding similar to the existing office for the Medicare Beneficiary Ombudsman, which received $1.8 million in FY 2015 for program operations. CBO estimates that implementing this provision would cost $18 million over the 2016-2026 period.

The legislation would direct the Government Accountability Office (GAO) and HHS to produce several reports on hearings and appeals issues that would not be funded by the amounts appropriated in Section 2. CBO estimates that two GAO reports would each cost about $1 million over the 2017-2018 period and three additional studies that HHS would be required to produce would cost $3 million over the 2017-2018 period.

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 S. 2368 Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015, as reported by the Senate Committee on Finance on December 8, 2015

	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	205	240	243	243	133	133	133	133	133	133	1,065	1,729

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 2026.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 2368 contains no intergovernmental or private-sector mandate as defined in UMRA and would impose no costs on state, local, or tribal governments.

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