Obamacare Program Integrity Provisions: Are They Vulnerable to Repeal?

Congressional Republican leaders plan to repeal the Affordable Care Act (Obamacare) using the budget reconciliation process in order to avoid a filibuster by Senate Democrats. Due to Senate rules, only provisions that either save or spend taxpayer dollars, such as enhanced provider screening (sec. 6401, see chart below) that was estimated to save $100 million dollars, may be repealed with a simple majority. Provisions that do not produce a change in outlays or revenues, such as the requirement for Medicaid RAC programs (see provision 6411in Subtitle E, below), may not be repealed with a simple majority because that provision has no budgetary impact.[1]

Congressional Republican leaders stated they will use a repeal bill passed earlier this year (H.R. 3762) as a model. This bill was passed using budget reconciliation by the House and Senate but was vetoed by President Obama. The Congressional Budget Office (CBO) scored H.R. 3762 as saving around $500 billion over 10 years. Republicans may wish to repeal program integrity and other deficit reducing provisions in order to put them towards another priority in the future, such as tax reform.

The chart below includes all of the program integrity provisions in Obamacare. As it illustrates, many of the provisions could have been repealed in H.R. 3762 but were not. In writing the new repeal bill that Congress intends to take up in February 2017, Congress may include the provisions below that either save or cost money. In particular, the reconciliation bill could repeal the additional funding for the Centers for Payment Integrity (Section 1303)

Description	Section	CBO Score 2010-2019 ($ in Billions)	Could be Repealed in 2017 Reconciliation Bill
Subtitle D—Reducing Fraud, Waste, and Abuse			
Limits community mental health center that may provide Medicare partial hospitalization services	1301	-0.6	Yes

[1] Scorekeeping Guideline #14 (which was adopted by Congress in the conference report for the Balanced Budget Act of 1997) states that "No increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for administration or program management activities.". This guideline applies to section 1303 (HCFAC) and section 6411 (RAC Program). If scoreable, the RAC Program and HCFAC spending would, over 10 years, save $200 million and $2.1 billion respectively.

Repeals Medicare prepayment medical review limitations to facilitate additional reviews designed to reduce fraud and abuse.	1302	-0.1	Yes
Makes additional appropriations to the Health Care Fraud and Abuse Control (HCFAC) Account of the Federal Hospital Insurance Trust Fund for FY2011-FY2016 and makes additional appropriations to the Medicaid Integrity Program for FY2010 and each subsequent year, indexed for inflation.	1303	0.3	Yes
90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers	1304	-0.2	Yes
Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions			
Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP	6401	-0.1	Yes
Requires the Medicaid Integrity Program and Medicaid Integrity Program contractors to provide the HHS and OIG with performance statistics. Federal matching funds may be withheld from states that do no report enrollee encounter data to MMIS in a timely manner. Increases funding for the Medicare Integrity Program by the percentage increase in the consumer price index over the previous year. Other Medicare and Medicaid Program Integrity Provisions	6402	-2.9	Yes
Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank	6403	0	No
Maximum Period for Submission of Medicare Claims	6404	0	No
Physicians Who Order Items or Services Required to Be Medicare-Enrolled Physicians or Eligible Professionals	6405	-0.4	Yes
Requirement for Physicians to Provide Documentation on Referrals to Programs At High Risk of Waste and Abuse	6406	0	No
Face to Face Encounter With Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare	6407	-1.0	Yes
Revises civil monetary penalties for making false statements or delaying inspections	6408	0	No
Medicare Self-Referral Disclosure Protocol	6409	0	No
Adjustments to the Competitive Acquisition Program in Medicare for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. Requires the Secretary to: (1) expand the	6410	-1.4	Yes

number of areas to be included in round two of the competitive bidding program from 79 to 100 of the largest metropolitan statistical areas; and (2) use competitively bid prices in all areas by 2016.			
Expands the Recovery Audit Contractor program to Medicaid, Medicare+Choice and Prescription Drug Program*	6411	0	No
Directs the U.S. Sentencing Commission to amend the Federal Sentencing Guidelines to provide two-level, three-level, and four-level increases in the offense level for any defendant convicted of a federal health care offense relating to a government health care program of a loss between $1 million and $7 million, between $7 million and $20 million, and at least $20 million, respectively.	10606	0	No
Subtitle F—Additional Medicaid Program Integrity Provisions			
Termination of Provider Participation Under Medicaid If Terminated Under Medicare or Other State Plan	6501	0	No
Medicaid Exclusion From Participation Relating to Certain Ownership, Control, and Management Affiliations	6502	0	No
Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid	6503	0	No
Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse	6504	0	No
Prohibition on Payments to Institutions or Entities Located Outside of the United States	6505	0	No
Overpayments	6506	0.1	Yes
Mandatory Medicaid Use of Medicare National Correct Coding Initiative	6507	-0.3	Yes