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## Obama Administration Releases FY 2017 Budget Proposal with Extensive Medicare & Medicaid Funding and Program Integrity Provisions

On February 9, 2016, the Obama Administration released its [proposed fiscal year \(FY\) 2017 budget](#), which contains significant Medicare and Medicaid reimbursement and program integrity legislative proposals – including \$419 billion in Medicare savings over 10 years. These proposed policy changes would require action by Congress, and Republican Congressional leaders have already voiced general opposition to the overall budget plan. In addition, many of these proposals have been included in prior Obama Administration proposed budgets without garnering Congressional support. Nevertheless, Medicare and Medicaid savings proposals often find their way into subsequent spending bills as offsets, so these budget policies are worth monitoring.

The largest pool of Medicare savings would result from various **Medicare prescription drug proposals**, which are summarized [in a separate post](#). Other significant savings (\$77 billion over 10 years) would be achieved by Medicare Advantage (MA) payment reforms, including the use of a competitive bidding system to establish rates for MA plans and standardization of quality bonus payments across counties. In addition, the budget proposal would allow the Secretary of Health and Human Services (HHS) to authorize MA organizations to deliver medical services via telehealth by eliminating otherwise applicable Part B requirements that certain covered services be provided exclusively through face-to-face encounters (an estimated \$160 million in savings over 10 years).

In addition, the budget calls for bundled **Medicare payments for post-acute providers** – long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs). Under

this proposal (which also was included in the Administration's FY 2016 budget proposal), payments would be bundled for at least half of the total payment for post-acute care providers beginning in 2021, with rates set to produce a permanent and total cumulative adjustment of -2.85 percent by 2023. Beneficiary coinsurance obligations would remain at current levels. The Administration estimates \$9.9 billion in savings over 10 years from this provision. The budget proposal also would reduce Medicare market-basket updates for post-acute care providers. Specifically, the update for IRFs, LTCHs, and HHAs would be reduced by 1.1 percentage points in FY 2017, and each year from FY 2019 through FY 2026 (the update for 2018 is currently set at 1 percent for these providers for 2018; the payment update would not drop below zero as a result of this proposal). The budget also would accelerate reductions in the market-basket update for SNFs, providing a -2.5 percent update in FY 2017; a -2 percent update in FY 2019; a -1 percent annual update in FYs 2020 through 2023; and a -0.97 percent update in FY 2024. Payment updates for SNFs *could* drop below zero as a result of this proposal. The revised updates would save \$86.6 billion over 10 years.

Other **Medicare payment/delivery reform provisions** in the budget include the following proposals, among others (all savings are over the 10-year period of FYs 2017-2026):

- Allow the Centers for Medicare & Medicaid Services (CMS) to base beneficiary assignment to a **Medicare Shared Savings Program accountable care organization (ACO)** on utilization of primary care services provided by nurse practitioners, physician assistants, clinical nurse specialists, Federally Qualified Health Centers, and Rural Health Clinics (\$230 million total), and allow ACOs participating in two-sided risk models to pay beneficiaries for a primary care visit (\$70 million).
- Establish **bonus payments for hospitals** that furnish a sufficient proportion of their services through eligible alternative payment entities, beginning in 2022. Bonuses would be available under the Inpatient Prospective Payment System permanently, and through the Outpatient Prospective Payment System until 2024. Reimbursement to other providers would be reduced by a percentage sufficient to ensure budget neutrality.
- Implement a budget-neutral, **value-based purchasing program** for several additional provider types, including SNFs, HHAs, ambulatory surgical centers, hospital outpatient departments, and community mental health centers beginning in 2018. At least 2 percent of payments would be tied to care quality and efficiency in the first two years of implementation, and at least 5 percent beginning in 2020.

- Revise the **Hospital Readmissions Reduction Program** to allow the Secretary to use a comprehensive “Hospital-Wide Readmission Measure” with broad categories of conditions rather than discrete “applicable conditions”; require hospitals to code conditions as “present on arrival” instead of “present on admission” under the **Medicare Hospital Acquired Conditions** (HAC) policy; and authorize the Secretary to determine through regulation the amount, scoring and penalty payment calculation methodology, and distribution of penalties to be assessed to eligible hospitals participating in the HAC Reduction Program (no budget impact).
- Strengthen the **Independent Payment Advisory Board (IPAB)** by reducing the target rate of Medicare cost growth from gross domestic product plus one percentage point to plus 0.5 percentage point beginning in 2018, which would make it easier to trigger Affordable Care Act (ACA) provisions requiring reductions to Medicare provider reimbursement (\$36.4 billion).
- Reduce Medicare coverage of **bad debts** from 65 percent in most cases to 25 percent over three years, starting in 2017 (\$32.9 billion).
- Reduce market-basket updates for **hospice providers** by 1.7 percent in 2018, 2019, and 2020 (updates would not drop below zero as a result of this proposal). The budget would also authorize the Secretary to implement a hospice-specific market basket by 2021, and make further budget-neutral reforms to the hospice payment system (\$9.3 billion).
- Exclude radiation therapy, therapy services, advanced imaging, and anatomic pathology services from the **in-office ancillary services exception** to the prohibition against physician self-referrals (Stark law), except in cases where a practice is “clinically integrated” and demonstrates cost containment, as defined by the Secretary, effective calendar year 2018 (\$5 billion).
- Allow the Secretary to introduce additional **primary care payments** into the Medicare Physician Fee Schedule beginning in calendar year 2017 (no budget impact).
- Authorize the Secretary to extend the competitive bidding program for **durable medical equipment, orthotics, and supplies** to additional categories of medical services currently excluded from the program, including inhalation drugs, all prosthetics and orthotics, and ostomy, tracheostomy, and urological supplies (\$3.8 billion).
- Repeal the 36-month rental cap for **oxygen equipment** and reduce the monthly payment amount for oxygen and oxygen equipment to remain budget-neutral.

- Provide that in order for a facility to be **classified as an IRF**, at least 75 percent of patient cases admitted must be required to meet one or more of 13 designated conditions beginning in 2017 (\$2.2 billion).
- Lower the threshold required for CMS to recoup differences between Clinical Laboratory Fee Schedule payments and invoice payments for new **advanced diagnostic laboratory tests**, from 130 percent to 100 percent beginning calendar year 2017 (no budget impact).
- Reduce Medicare **indirect medical education** add-on payments by 10 percent beginning in 2017 (\$17.8 billion).
- Beginning in 2017, reduce **critical access hospital** (CAH) reimbursement from 101 percent to 100 percent of costs (\$1.7 billion), and limit CAH designation eligibility for hospitals within 10 miles of another hospital (\$880 million).

Separately, the budget would achieve Medicare savings by increasing income-related premiums under Parts B and D (\$41.2 billion); modifying the Part B deductible for new beneficiaries (\$4.2 billion); and establishing a new home health copayment (\$1.3 billion).

In addition, the proposed budget includes several provisions that would reform the **Medicare appeals process**. For instance, the budget would: allow HHS to retain a portion of Recovery Audit Contractor (RAC) recoveries to fund related appeals; establish a filing fee for Medicare Parts A and B appeals that would be returned to appellants with a fully favorable determination; increase the minimum amount in controversy required for Administrative Law Judge adjudication to \$1,500; allow the Office of Medicare Hearings and Appeals (OMHA) to use Medicare magistrates for appealed claims below the amount in controversy threshold; establish expedited OMHA procedures for claims with no material fact in dispute; remand an appeal to the first level of review when new documentary evidence is submitted at the second level of appeal or above; and authorize the Secretary to adjudicate appeals through the use of sampling and extrapolation techniques

Other provisions of the budget that would **increase Medicare spending** include proposals to:

- Include psychiatric hospitals, community mental health centers, residential and outpatient mental health and substance use disorder treatment clinics, and psychologists in the Medicare and Medicaid Electronic Health Record Incentive Programs (\$760 million in Medicare costs over 10 years).
- Eliminate the 190-day lifetime limit on inpatient services delivered in specialized psychiatric hospitals (\$2.4 billion in costs).

- Increase Medicare disproportionate share payments to hospitals in Puerto Rico (\$70 million in costs).
- Eliminate beneficiary coinsurance for screening colonoscopies with polyp removal (\$2.4 billion in costs).

With regard to **Medicaid**, the budget includes a number of proposals to reduce Medicaid drug spending, as discussed [in this separate post](#). In addition, the budget would rebase Medicaid disproportionate share hospital allotments beginning in 2026 to account for coverage expansion under the ACA (\$6.6 billion over 10 years). Furthermore, the Administration proposes a number of policies related to Medicaid eligibility. Most notably, the budget would give states more time to expand Medicaid program eligibility to individuals with income below 133 percent of the poverty line, and qualify for the ACA's full federal support of expansion costs for the first three years of expansion (\$26 billion/10 year cost) – a provision unlikely to gain much traction among Republican Congressional leaders. The budget also includes additional initiatives to support state efforts to transition disabled and elderly individuals from institutions to community-based care.

The budget proposal includes additional spending on **public health initiatives** outside of the Medicare and Medicaid programs, including a proposal to address opioid abuse, misuse, and overdose through a \$1 billion initiative to expand access to treatment. The budget also proposes a two-year initiative to expand access to mental health services through \$500 million in new mandatory funding.

The proposed budget includes a number of new **Medicare and Medicaid program integrity** funding and legislative proposals intended to enhance oversight and cut fraud, waste, and abuse. Among other things, the budget would:

- Expand funding for the Medicare Fraud Strike Force program to expand capacity, support rigorous data analysis, and increase focus on civil fraud, such as off-label marketing and pharmaceutical fraud, and increase Medicaid Integrity Program funding.
- Authorize the HHS Secretary to suspend coverage and payment for Part D prescriptions when they are prescribed by providers who have been engaged in misprescribing or overprescribing drugs with abuse potential.
- Authorize the HHS Secretary to require additional clinical information on certain Part D prescriptions, such as diagnosis and incident codes, as a condition of coverage (\$780 million in savings over 10 years).
- Expand CMS's authority to require prior authorization for all Medicare fee-for-service items, particularly those at highest risk of improper payment (\$75 million in savings).

- Authorize civil monetary penalties for providers and suppliers that do not update enrollment records (\$32 million).
- Authorize the Secretary to assess an administrative fee on providers for claims that have not been properly documented for high-risk, high-cost items. The fee, which would equal \$50 per Part B item/service and \$100 per Part A service, would be implemented after one year of instructional billing (no budget impact).
- Establish a registration process for clearinghouses and billing agents that act on behalf of Medicare providers and suppliers (no budget impact).
- Allow the Secretary to collect a \$50 Medicare application fee for individual providers (in addition to the existing fee on institutional providers; the fee would be adjusted annually for inflation (no budget impact).
- Authorize CMS to pay RACs after the second level of appeals, and require RACs to maintain a surety bond to cover overturned decisions (no budget impact).
- Require states to track high prescribers and utilizers of Medicaid prescription drugs (\$770 million).
- Provide CMS more flexibility to disallow individual payments or partial payments associated with Medicaid managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (no budget impact).
- Require state Medicaid agencies to suspend payments to providers when the Secretary determines that the providers pose a significant risk of fraud (unless the state demonstrates that the benefits of continuing the payments outweigh the risk of losses) (no budget impact).
- Authorize Medicaid Fraud Control Units to investigate and prosecute allegations of abuse or neglect of Medicaid beneficiaries in non-institutional settings (no budget impact).
- Expand the current authority to exclude individuals and entities from federal health programs if they are affiliated with a sanctioned entity by closing a “loophole” that allows an officer, managing employee, or owner of a sanctioned entity to avoid exclusion by resigning his or her position or divesting his or her ownership; and extending the exclusion authority to entities affiliated with a sanctioned entity (\$70 million).
- Allow the Secretary to reject claims from new providers and suppliers located outside of a temporary enrollment moratoria location that are furnished to beneficiaries located inside that area. This provision is

intended to address situations in which “[s]ome providers and suppliers are circumventing the moratoria by enrolling in localities just outside the moratorium area” (\$50 million).

- Enable federal and state governments to confidentially share data algorithms developed to detect waste, fraud, and abuse. The budget notes that “[s]hould various aspects of these algorithms become known, fraudsters could utilize the information to re-direct their schemes to other areas of the Medicare, Medicaid, and CHIP programs or adjust their schemes to avoid detection” (\$90 million).
- Allow CMS to publish the National Provider Identifier (NPI) of covered recipients on the Open Payments website to make it easier for data users to connect Open Payments records with covered recipient information (no budget impact).

*Note that the budget proposal includes numerous other proposals impacting programs and operations throughout the HHS agencies.*

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