Congressional Research Service
Informing the legislative debate since 1914

President's FY2016 Budget: Centers for Medicare & Medicaid Services (CMS) Legislative Proposals

Alison Mitchell, Coordinator
Analyst in Health Care Financing

Kirstin B. Blom, Coordinator
Analyst in Health Care Financing

Patricia A. Davis, Coordinator
Specialist in Health Care Financing

March 9, 2015

Congressional Research Service
7-5700
www.crs.gov
R43934

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Federal law requires the President to submit an annual budget request to Congress no later than the first Monday in February. The budget informs Congress of the President's overall federal fiscal policy based on proposed spending levels, revenues, and deficit (or surplus) levels. The budget request lays out the President's relative priorities for federal programs, such as how much should be spent on defense, education, health, and other federal programs. The President's budget also may include legislative proposals for spending and tax policy changes. While the President is not required to propose legislative changes for those parts of the budget that are governed by permanent law (i.e., mandatory spending), such changes generally are included in the budget. President Obama submitted his FY2016 budget request to Congress on February 2, 2015.

The Centers for Medicare & Medicaid Services (CMS) is the division of the Department of Health & Human Services (HHS) responsible for administering Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). CMS also is responsible for administering the private health insurance programs established in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). CMS is the largest purchaser of health care in the United States, with expenditures from CMS programs accounting for almost 30% of the nation's health expenditures. In FY2016, CMS estimates that almost 126 million individuals will receive coverage through Medicare, Medicaid, and CHIP.

The CMS budget includes a mixture of both mandatory and discretionary spending. However, the vast majority of the CMS budget is mandatory spending, such as Medicare benefit spending and grants to states for Medicaid. In the President's FY2016 budget, proposed Medicare outlays make up 60% of the CMS budget and proposed Medicaid outlays comprise 36% of the CMS budget.

The CMS budget is divided into the following sections: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance protections and programs, the Center for Medicare & Medicaid Innovation, and program management. The President's FY2016 budget contains a number of legislative proposals that would affect the CMS budget. Some of these proposals are program expansions, and others are designed to reduce federal spending.

The President's proposed budget for CMS would be $970.8 billion in net mandatory and discretionary outlays for FY2016, which would be an increase of $73.6 billion, or 8.2%, over the estimated net outlays for FY2015. This estimate includes the cost of the Medicare physician payment adjustment ($8.8 billion), the net cost of legislative proposals ($5.4 billion), and the estimated savings from program integrity investments ($0.9 billion).

This report begins with summaries of each section of the CMS budget. Then, for each legislative proposal included in the President's budget, this report provides a description of current law and the President's legislative proposal. The President's budget includes legislative proposals for the following sections of CMS: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, and program management. A table summarizing the Administration's estimates of the budgetary impact for each legislative proposal is at the end of each of these sections.

Contents

Tables

Appendixes

Contacts

Introduction

Federal law requires the President to submit an annual budget request to Congress no later than the first Monday in February.[1] The budget informs Congress of the President's overall federal fiscal policy based on proposed spending levels, revenues, and deficit (or surplus) levels. The budget request lays out the President's relative priorities for federal programs, such as how much should be spent on defense, education, health, and other federal programs. The President's budget also may include legislative proposals for spending and tax policy changes. Although the President is not required to propose legislative changes for those parts of the budget that are governed by permanent law (i.e., mandatory spending), such changes generally are included in the budget. President Obama submitted his FY2016 budget request to Congress on February 2, 2015.

The Centers for Medicare & Medicaid Services (CMS) is the division of the Department of Health & Human Services (HHS) responsible for administering Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). CMS also is responsible for administering the private health insurance programs established in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

CMS is the largest purchaser of health care in the United States, with Medicare and federal Medicaid expenditures accounting for almost 30% of the total national health expenditures in 2013.[2] In FY2016, CMS estimates 126 million individuals will be covered by Medicare, Medicaid, or CHIP.[3]

This report summarizes the President's budget request for each of the following sections of the CMS budget: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance protections and programs, the Center for Medicare & Medicaid Innovation, and program management. Then, for each legislative proposal included in the President's budget, this report provides a description of current law and the President's proposal. The President's budget includes legislative proposals for the following sections of CMS: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, and program management. At the end of each of these sections, a table summarizes the Administration's estimates of costs or savings associated with each legislative proposal.

[1] 31 U.S.C. 1105(a).

[2] Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, National Health Expenditures Data, 2014.

[3] Department of Health & Human Services (HHS), *Centers for Medicare & Medicaid Services: Fiscal Year 2016 Justification of Estimates for Appropriations Committees*, February 2, 2015.

Basic Budget Terminology

Budget Authority: When Congress appropriates money, it provides *budget authority*, that is, authority to enter into obligations. Budget authority also may be provided in legislation that does not go through the appropriations process (i.e., mandatory or direct spending legislation).

Discretionary Spending: Refers to budget authority and outlays that are provided in and controlled by appropriation acts.

Mandatory Spending: Refers to budget authority that is provided outside of the annual appropriations process (i.e., through authorizing legislation) and the outlays that result from such budget authority.

Outlays: Spending to pay a federal obligation. Occur when obligations are liquidated, primarily through the issuance of checks, electronic fund transfers, or the disbursement of cash.

Offsetting Receipts: Certain receipts of the federal government are accounted for as *offsets* against outlays rather than as revenues, such as Medicare Part B and Part D premiums.

Note: For more information about the federal budget process, see CRS Report 98-721, *Introduction to the Federal Budget Process*, coordinated by Bill Heniff Jr.

Budget Summary

The CMS budget includes both mandatory and discretionary spending. However, a vast majority of CMS spending is mandatory, such as Medicare benefit spending and grants to states for Medicaid. **Table 1** shows the President's proposed FY2016 budget for CMS.

Table 1. President's Proposed FY2016 Budget for the Centers for Medicare & Medicaid Services

(dollars in billions)

	Actual FY2014	FY2015	FY2016	FY2015-FY2016 $ Change	FY2015-FY2016 % Change
Current Law	$826.7	$886.8	$957.4	$70.6	8.0%
Adjusted Baseline	0.0	5.3	8.8	3.4	64.6%
Legislative Proposals	0.0	5.1	5.4	0.3	6.5%
Savings from Program Integrity[a]	0.0	0.0	-0.9	-0.9	—
Total Net Outlays	**$826.7**	**$897.2**	**$970.8**	**$73.6**	**8.2%**

Source: Table created by the Congressional Research Service (CRS) based on data from the Department of Health and Human Services (HHS), *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Totals may not add due to rounding.

a. Includes savings not subject to pay-as-you-go (PAYGO) from additional program integrity investments above savings already assumed in current law.

Current Law: The President's budget projects that under current law CMS mandatory and discretionary net outlays would total $957.4 billion in FY2016,[4] which is an increase of $70.6 billion, or 8.0%, over the estimated net outlays for FY2015.

[4] The figures in this report are taken from the following two documents: HHS, *Fiscal Year 2016 Budget in Brief*: (continued...)

Adjusted Baseline: The President's FY2016 budget would increase baseline Medicare spending by assuming Medicare payments for physician services will remain at current levels rather than decrease significantly according to the sustainable growth rate (SGR) formula under current law.[5] The President's budget estimates this adjustment will increase CMS's net outlays by $5.3 billion in FY2015 and $8.8 billion in FY2016. With this adjustment, CMS's total net outlays are estimated to be $966.2 billion in FY2016.

Legislative Proposals: The President's FY2016 budget includes a number of legislative proposals for Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, and program management. The Administration estimates that if these legislative proposals are implemented, CMS's total net outlays would increase by $5.1 billion in FY2015 and a net of $5.4 billion in FY2016.

Total Net Outlays: With the Medicare physician payment adjustment, the estimated impact of the legislative proposals, and the estimated savings from program integrity activities ($0.9 billion), the President's budget estimates CMS's net outlays would be $970.8 billion in FY2016, which is an increase of $73.6 billion, or 8.2%, over the estimated net outlays for FY2015.

The CMS budget is divided into the following sections: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance protections and programs, the Center for Medicare & Medicaid Innovation, and program management. A description of each of these sections appears below, along with a summary of the President's budget proposals for each section.

Medicare

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals aged 65 and older. Over the years, Medicare has been expanded to include individuals under the age of 65 who cannot work because they have a medical condition that is expected to last at least one year or result in death, have end-stage renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease). Medicare, which consists of four parts (A-D), covers hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, and hospice care, among other services.[6]

The President's budget projects that under current law, Medicare outlays net of offsetting receipts will be $583.5 billion in FY2016, which is an increase of $53.0 billion, or 10.0%, over FY2015 (see **Table 2**). The President's budget makes adjustments to the baseline assuming congressional

(...continued)

Strengthening Health and Opportunity for All Americans, February 2015, p. 60-118, at http://www.hhs.gov/budget/fy2016/fy-2016-budget-in-brief.pdf and HHS, *Centers for Medicare & Medicaid Services: Fiscal Year 2016 Justification of Estimates for Appropriations Committees,* February 2015, at http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf.

[5] For more information about Medicare physician payments, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

[6] For more information about the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

action preventing a reduction in Medicare physician payments for FY2016, which increases the FY2016 baseline outlays net of offsetting receipts by $8.8 billion. The budget includes a number of legislative proposals for Medicare, including some legislative proposals in the program management section.[7] If implemented, these legislative proposals in Medicare and program management are estimated to decrease Medicare outlays by a net of $1.8 billion in FY2016 and a cumulative $423.1 billion over the next 10 years.[8] With the baseline adjustments and the estimated impact of the legislative proposals, the President's budget estimates that Medicare's total net mandatory and discretionary outlays for FY2016 will be $590.5 billion, which is an increase of $54.1 billion, or 10.1%, over FY2015.

Table 2. President's Proposed FY2016 Budget for the Centers for Medicare & Medicaid Services by Budget Section

(dollars in billions)

	Actual FY2014	FY2015	FY2016	FY2015-FY2016	
				$ Change	% Change
Medicare					
Current Law	$511.7	$530.5	$583.5	$53.0	10.0%
Physician Payment Adjustment	0.0	5.3	8.8		
Legislative Proposals	0.0	0.6	-1.8[a]		
Subtotal	511.7	536.4	590.5	54.1	10.1%
Medicaid					
Current Law	301.5	328.6	344.4	15.8	4.8%
Legislative Proposals	0.0	4.5	6.6		
Subtotal	301.5	333.1	351.0	17.9	5.4%
CHIP					
Current Law	9.3	10.6	14.0	3.4	32.1%
Legislative Proposals	0.0	0.0	0.6		
Subtotal	9.3	10.6	14.6	4.0	37.7%
State Grants and Demonstrations					
Current Law	0.5	0.6	0.6	[b]	3.7%
Legislative Proposals	0.0	0.0	[c]		
Subtotal	0.5	0.6	0.6	[d]	8.0%
Private Health Insurance Programs					
Current Law	2.7	15.3	13.3	-2.0	-13.1%
Center for Medicare & Medicaid Innovation					

[7] The "Medicare Legislative Proposals" and "Program Management Legislative Proposals" sections in this report include an explanation of current law and a description of each legislative proposal pertaining to the Medicare program. Tables at the end of each section summarize the costs or savings for each of the President's legislative proposals.

[8] The $1.8 billion in savings includes $2.4 billion in net savings from Medicare legislative proposals net of premiums and offsetting receipts, in addition to the cost of $0.6 billion for program management legislative proposals.

	Actual FY2014	FY2015	FY2016	FY2015-FY2016 $ Change	FY2015-FY2016 % Change
Current Law	1.0	1.3	1.6	0.3	23.1%
Savings from Program Integrity[e]	0.0	0.0	-0.9	-0.9	
Total Net Outlays	**$826.7**	**$897.2**	**$970.8**	**$73.6**	**8.2%**

Source: Table created by the Congressional Research Service (CRS) based on data from the Department of Health and Human Services (HHS), *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Funding for program management activities is included in the estimates in this table where appropriate. Totals may not add due to rounding.

CHIP: State Children's Health Insurance Program.

a. The $1.8 billion in savings includes $2.4 billion in savings from Medicare legislative proposals net of premiums and offsetting receipts, in addition to the cost of $0.6 billion for program management legislative proposals.

b. Funding for state grants and demonstrations is to increase by $21 million from FY2015 to FY2016.

c. The Administration estimates the legislative proposals for state grants and demonstrations would cost $25 million in FY2016.

d. With the legislative proposals included, the Administration estimates funding for state grants and demonstrations would increase by $46 million from FY2015 to FY2016.

e. Includes savings not subject to pay-as-you-go (PAYGO) from additional program integrity investments above savings already assumed in current law.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports. Medicaid is jointly funded by the federal government and the states. The federal government reimburses states for a portion (i.e., the federal share) of each state's Medicaid program costs. Because federal Medicaid funding is an open-ended entitlement to states, there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.[9]

The President's budget projects that under current law Medicaid total net outlays will be $344.4 billion in FY2016, which is an increase of $15.8 billion, or 4.8%, over FY2015 (see **Table 2**).[10] The President's budget includes a number of legislative proposals that would impact Medicaid.[11] If these proposals are implemented, the President's budget estimates that total net outlays for Medicaid would increase by $6.6 billion in FY2016 and by a cumulative $26.7 billion over the

[9] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[10] The federal Medicaid budget consists of funding for benefits and state administration. According to the President's budget, under current law, outlays for benefits are expected to increase by $17.3 billion, or 5.6%, and outlays for state administration are estimated to decrease by $1.5 billion, or 7.6%, in FY2016.

[11] The "Medicaid Legislative Proposals" section below includes a brief discussion of current and proposed law for each of the legislative proposals for the Medicaid program. A table at the end of the section summarizes the costs or savings for each of these proposals.

next 10 years.[12] Including the estimated impact of the legislative proposals, the President's budget estimates FY2016 net outlays for Medicaid would total $351.0 billion, which is an increase of $17.9 billion, or 5.4%, over FY2015.

Program Integrity

Title II of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse. HCFAC has traditionally focused on Medicare fraud, waste, and abuse through activities such as medical review, benefit integrity, and provider audits. In FY2009, discretionary funding was appropriated that allowed HCFAC to expand its activities to Medicare Advantage and Medicare Part D, among other things. In addition, HCFAC mandatory and discretionary funding is used to prevent fraud, waste, and abuse in the Medicaid program.

Spending on program integrity activities is built into the President's budget summaries discussed above for Medicare and Medicaid and is not explicitly broken out in **Table 2**. However, when the funding for program integrity activities is broken out, the President's budget requests total budget authority for those activities of $2.0 billion in FY2016, including $1.3 billion in mandatory funding for program integrity activities and $0.7 billion in discretionary funding. This funding level is an increase of $0.1 billion, or 5.3%, over FY2015.[13]

CHIP

The Balanced Budget Act of 1997 (BBA97; P.L. 105-33) established the State Children's Health Insurance Program (CHIP) to provide health insurance coverage to targeted, low-income children in families that have annual income above Medicaid eligibility levels but have no health insurance. Authorization and funding for CHIP has been extended a number of times. Most recently, the ACA extended federal funding for CHIP through FY2015. CHIP is funded jointly by the federal government and the states, and federal CHIP funding is capped on a state-by-state basis according to annual allotments (i.e., federal funds allocated to each state for the federal share of its CHIP expenditures).[14]

The President's budget projects that under current law CHIP's total outlays will be $14.0 billion in FY2016, which is an increase of $3.4 billion, or 32.1%, over FY2015 (see **Table 2**).[15] Federal funding for CHIP is expected to increase significantly because under current law, the federal

[12] These figures include the Medicaid interaction, which are legislative proposals for other departments or agencies that are estimated to have a budgetary effect on Medicaid. The Medicaid interactions are estimated to decrease federal Medicaid outlays by $0.1 billion in FY2016 and $8.1 billion over the next 10 years.

[13] The "Program Integrity Legislative Proposals" section below includes a description of current and proposed law for each of the program integrity legislative proposals. A table at the end of each section summarizes the costs or savings associated with each of the President's legislative proposals.

[14] For more information about the State Children's Health Insurance Program (CHIP), see CRS Report R43627, *State Children's Health Insurance Program: An Overview*, by Evelyne P. Baumrucker and Alison Mitchell.

[15] The federal CHIP budget consists of outlays for the state allotments and the Child Enrollment Contingency Fund, which contains funds available to states with a federal CHIP funding shortfall and CHIP enrollment for children above a target enrollment level. The President's budget estimates outlays for benefits and state administration will increase by $3.5 billion, or 32.7%, from FY2015 to FY2016, and outlays for the Child Enrollment Contingency Fund will decline from $50 million to zero from FY2015 to FY2016.

matching rate for CHIP is to increase by 23 percentage points in FY2016.[16] The President's budget includes legislative proposals that would impact CHIP.[17] If these proposals are implemented, the President's budget estimates CHIP outlays would increase by $0.6 billion in FY2016 and by $35.1 billion over the next 10 years.

State Grants and Demonstrations

The state grants and demonstrations portion of the budget funds a diverse set of grant programs and other activities. The grants and activities funded through this portion of the budget include the Money Follows the Person Demonstration, the Medicaid Integrity Program, incentives for prevention of chronic diseases in Medicaid, demonstrations to improve community mental health services, and the Medicaid psychiatric residential treatment demonstration.[18]

The President's budget projects that under current law FY2016 total outlays for state grants and demonstrations will be $0.6 billion, which is an increase of 3.7% from FY2015 (see **Table 2**). The President's budget includes a few legislative proposals impacting the budget for state grants and demonstrations that are estimated to increase funding by $0.6 billion over the next 10 years.[19]

Private Health Insurance Protections and Programs

The ACA included reforms that focus on restructuring the private health insurance market by creating new programs (e.g., health insurance exchanges) and imposing requirements on private health insurance plans.[20] The Center for Consumer Information and Insurance Oversight within CMS is charged with helping implement the provisions of the ACA related to the private health insurance programs.

The President's budget projects that under current law total outlays for the private health insurance protections and programs will be $13.3 billion in FY2016, which is a decrease of $2.0 billion, or 13.1%, from FY2015 (see **Table 2**). The major changes for private health insurance protections and programs include a reduction of $2.5 billion in funding for the Transitional Reinsurance Program[21] that is offset by increases in funding for the Risk Adjustment Program[22]

[16] Although FY2015 is the last year states are to receive CHIP allotments, there are expected to be federal CHIP outlays in FY2016 because states will have access to unspent funds from their FY2015 allotments and unspent FY2014 allotments redistributed to shortfall states (if any).

[17] The "CHIP Legislative Proposals" section includes a brief discussion of current and proposed law for each of the legislative proposals impacting CHIP. A table at the end of each section summarizes the costs or savings associated with each of these proposals.

[18] For more information about these programs, see HHS, *Centers for Medicare & Medicaid Services: Fiscal Year 2016 Justification of Estimates for Appropriations Committees*, at http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf.

[19] The "State Grants and Demonstrations Legislative Proposals" section includes a brief discussion of current and proposed law for each of the legislative proposals impacting state grants and demonstrations. A table at the end of each section summarizes the costs or savings associated with each of these proposals.

[20] For more information about the private health insurance protections and programs, see CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Namrata K. Uberoi and CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[21] Under the Transitional Reinsurance Program, contributions are collected from health insurance issuers and group health plans to fund payments to issuers of non-grandfathered individual market plans that enroll high-cost individuals.

($2.5 billion) and health insurance exchange grants ($1.8 billion). The President's budget does not include any legislative proposals impacting the private health insurance protections and programs.

Center for Medicare & Medicaid Innovation

Section 3021 of the ACA established the Center for Medicare & Medicaid Innovation (the Innovation Center), which is tasked with testing innovative health care payment and delivery models with the potential to improve quality of care and reduce Medicare and Medicaid expenditures. The ACA appropriated $10 billion to support the Innovation Center activities from FY2011 through FY2019. The Innovation Center initiatives include Partnership for Patients, Health Care Innovation Awards, bundled payments, Accountable Care Organizations (ACOs), the Federally-Qualified Health Center Advanced Primary Care Practice demonstration, the comprehensive primary care initiative, and the Strong Start initiative.[23]

The President's budget projects that under current law total outlays for the Innovation Center will be $1.6 billion in FY2016, which is an increase of $0.3 billion, or 23.1%, from FY2015 (see **Table 2**). The President's budget does not include any legislative proposals impacting the Innovation Center.

Program Management

The program management portion of the CMS budget includes funding for the administration of Medicare, Medicaid, CHIP, and other CMS activities. Funding for program management activities is included the budget summaries discussed above but is not explicitly broken out in **Table 2**. However, when the funding for program management activities is broken out, the President's budget projects that under current law spending for program management activities (including both discretionary budget authority and mandatory spending) will be $6.8 billion in FY2016,[24] which is an increase of $1.1 billion, or 18.2%, over the FY2015 level.

Funding for program management consists of both discretionary and mandatory funding. The discretionary funding for program management activities is projected to be $4.2 billion in FY2016, which is an increase of $0.3 billion, or 6.8%, over FY2015 funding. The discretionary funding for program management activities is broken into five different budget lines—program operations, federal administration, survey and certification, research, and state high-risk pools.[25]

(...continued)

[22] Under the Risk Adjustment Program, CMS collects charges from health insurance issuers that enroll healthier-than-average enrollees and redistributes those funds to health insurance issuers that enroll sicker-than-average enrollees.

[23] For more information about these initiatives, see HHS, *Centers for Medicare & Medicaid Services: Fiscal Year 2016 Justification of Estimates for Appropriations Committees*, February 2015, at http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf.

[24] The President's budget request for CMS's program management activities includes an adjustment for reimbursable administration, which is an offsetting collection from non-federal sources estimated to be $2.5 billion in FY2016. This reimbursable administration adjustment includes health insurance exchanges, risk adjustments, Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, Medicare Advantage/prescription drug program education campaign, recovery audit contractors, and provider enrollment fees.

[25] For more information about each of these activities, see HHS, *Centers for Medicare & Medicaid Services: Fiscal Year 2016 Justification of Estimates for Appropriations Committees,* February 2015, at http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf.

Under current law, the mandatory funding for program management activities is projected to be $0.1 billion in FY2016, which is a $0.2 billion decrease from FY2015 funding levels.

The President's budget includes a few legislative proposals that would impact program management activities. If these proposals are implemented, the President's budget estimates that total program level funding for program management activities would increase by $1.0 billion in FY2016.[26]

Including the impact of the legislative proposals, the President's budget estimates total program level funding for program management activities would be $7.9 billion in FY2016, which is an increase of $2.1 billion, or 36.5%, over FY2015. When risk corridor[27] spending is included the estimated program level funding for program management activities increases to $14.3 billion in FY2016.

Legislative Proposals

The President's FY2016 budget contains a number of proposals that would impact the CMS budget. Some of these proposals are program expansions, and others are designed to reduce federal spending. For each proposal, this report provides a description of current law and the President's proposal.[28] This report groups these legislative proposals by the following program areas: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, and program management. A table at the end of each of these sections summarizes the Administration's estimates of costs or savings associated with each legislative proposal and classifies each proposal as new, modified from the President's FY2015 budget, or repeated from the President's FY2015 budget.[29] The **Appendix** includes a list of acronyms that are used throughout the legislative proposal sections.

[26] The legislative proposals impacting the mandatory funding for program management are discussed in the "Program Management Legislative Proposals" section of the CMS budget. A table at the end of the section summarizes the costs or savings associated with each of these proposals.

[27] The temporary risk corridors program protects qualified health plans from uncertainty in rate setting from CY2014 through CY2016 through shared risk in losses and gains.

[28] When years are not specified as a fiscal year, calendar year, plan year, or rate year, the type of year is not clearly identified in the President's budget documents.

[29] Legislative proposals classified as "repeated" might have different start dates than the FY2015 proposal due to the start date from the FY2015 budget lapsing or legislation having been enacted that impacted the start date from the FY2015 budget.

Medicare Legislative Proposals

Medicare Part A

Establish a Hospital-Wide Readmissions Reduction Measure

Current Law

Acute care hospitals (or inpatient prospective payment system hospitals) with higher than expected readmission rates for Medicare aged beneficiaries who were initially admitted to the hospital for one of five conditions are subject to up to a 3% reduction of their base discharge payment amount. CMS has established a hospital-wide all-cause readmission measure that has been implemented as part of its quality reporting program. As noted on page 50027 of the August 22, 2014, *Federal Register*, which discusses the FY2015 inpatient prospective payment system final rule, CMS believes the definition of applicable condition in Section 1886(q)(5) A) of the Social Security Act (which establishes the Hospital Readmissions Reduction Program) prohibits the adoption of the many categories of diagnosis and procedures comprising the hospital-wide all-cause readmission measure as a single "condition."

President's Proposal

The President's budget would permit the Secretary of HHS[30] to adopt a comprehensive hospital-wide measure of readmissions as part of Medicare's Hospital Readmissions Reduction Program in a budget-neutral fashion. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Extend Accountability for Hospital-Acquired Conditions

Current Law

Acute care hospitals are required to submit information indicating whether conditions established by principal and secondary diagnosis are present on admission for Medicare inpatient discharges on or after October 1, 2007. *Present on admission* is defined as present at the time the hospital's order for admission occurs. Depending upon the timing of that order, conditions that develop during an outpatient encounter at the hospital, such an emergency department visit, may or may not be considered present on admission.

President's Proposal

The President's budget would require hospitals to code patients' conditions as *present on arrival at a hospital* instead of *present on admission* for the purposes of Medicare's Hospital-Acquired

[30] Hereinafter, "the Secretary" refers to the Secretary of HHS unless otherwise specified.

Condition reporting and payment program. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Reduce Medicare Coverage of Bad Debts

Current Law

Medicare reimburses providers for beneficiaries' unpaid coinsurance and deductible amounts after reasonable collection efforts. Medicare providers that receive bad debt reimbursement include hospitals, skilled nursing facilities (SNFs), critical access hospitals, rural health clinics, federally qualified health clinics, community mental health clinics, end-stage renal disease facilities, health maintenance organizations reimbursed on a cost basis, competitive medical plans, and health care prepayment plans.

Historically, Medicare reimbursed 100% of these bad debts. BBA97 had scheduled bad debt in hospitals to be reduced from 100% reimbursement to 75% reimbursement in FY1998, to 60% reimbursement in FY1999, and to 55% reimbursement in subsequent years. However, **t**he Benefits Improvement and Protection Act of 2000 (incorporated into the Consolidated Appropriations Act of 2001; P.L. 106-554) froze the reduction at 70% reimbursement in FY2001 and for subsequent years. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) reduced the payment amount for Medicare-allowable SNF bad debt from 100% to 70%, except for the bad debt attributable to beneficiaries eligible for both Medicare and Medicaid (i.e., dual-eligible beneficiaries), effective for cost reporting periods beginning on or after October 1, 2005. For other Medicare providers, allowable beneficiary bad debt had been reimbursed at 100%. The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) reduced Medicare bad debt reimbursement to 65% for all providers. Providers that were reimbursed at 70% received 65% bad debt reimbursement beginning in FY2013. Other providers that were reimbursed at 100% of bad debt were reimbursed at 88% in FY2013 and at 76% in FY2014, and they are to be reimbursed at 65% in FY2015 and subsequent years.

President's Proposal

The President's budget would reduce bad debt reimbursement to 25%. The scheduled reduction would be phased in over three years beginning in FY2016 for all providers that receive bad debt payments. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $31.1 billion over the next 10 years.

Better Align Graduate Medical Education Payments with Patient Care Costs

Current Law

Medicare pays hospitals with approved medical residency programs an additional amount to support the higher costs of patient care associated with training physicians. These indirect medical education payments are calculated as a percentage increase to Medicare's inpatient

payment rates. The indirect medical education payments vary depending on the size of the hospital's teaching program (subject to Medicare's cap) as measured by the hospital's ratio of residents to hospital beds. Generally, teaching hospitals receive a 5.5% increase in indirect medical education payments for every 10% increase in their resident-to-bed ratio. The Medicare Payment Advisory Commission (MedPAC) has found that less than half of the indirect medical education payments can be justified empirically. In its June 2010 report, MedPAC recommended that Medicare's funding of graduate medical education be changed to support the workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality and that the Secretary set standards for receiving such funds. These standards should be ambitious goals for practice-based learning and improvement, interpersonal and communications skills, professionalism, and systems-based practice, including interaction of community-based care with hospital care.

President's Proposal

The President's budget would reduce indirect medical education funding by a total of 10%, starting in FY2016. The Secretary would be given the authority to set standards for teaching hospitals to encourage the training of primary care residents and emphasize skills that promote high-quality and high-value health care. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $16.3 billion over the next 10 years.

Eliminate the 190-Day Lifetime Limit on Inpatient Psychiatric Facility Services

Current Law

Medicare Part A covers mental health services that require an inpatient admission either in a general hospital or in a psychiatric hospital that primarily provides services to patients with mental health conditions. Medicare will pay for no more than 190 days of care in a freestanding inpatient psychiatric hospital during a beneficiary's lifetime. This limit does not apply to days provided by a distinct psychiatric unit that is part of a general hospital.

President's Proposal

The President's budget would remove Medicare's 190-day lifetime limit on freestanding inpatient psychiatric facilities. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $5.0 billion over the next 10 years.

Reduce Critical Access Hospital Reimbursements from 101% of Reasonable Costs to 100% of Reasonable Costs

Current Law

As established by BBA97, critical access hospitals (CAHs) are limited-service rural facilities that meet certain distance criteria or have been designated as necessary providers, offer 24-hour

emergency care, have no more than 25 acute care inpatient beds, and have no more than a 96-hour average length of stay.

Generally, CAHs receive enhanced cost-based Medicare payments, rather than the payments paid to acute care hospitals under Medicare's prospective payment systems (PPS). Since FY2004, CAHs have received 101% of reasonable, cost-based reimbursement for inpatient care, outpatient care, ambulance services, and SNF care provided in swing beds to Medicare beneficiaries. Prior to this date, CAHs received Medicare payment based on 100% of reasonable costs for these services.

President's Proposal

The President's budget would reduce Medicare's reimbursement to CAHs to 100% of reasonable costs, beginning in FY2016. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $1.7 billion over the next 10 years.

Prohibit Critical Access Hospital Designation for Facilities That Are Less Than 10 Miles from the Nearest Hospital

Current Law

To be certified as a CAH, a rural entity must meet certain distance criteria or have been designated as a necessary provider by the state. Under federal distance standards, a CAH must meet one of the following criteria: (1) be located 35 miles from another hospital or (2) be located 15 miles from another hospital in areas with mountainous terrain or with only secondary roads. Until January 1, 2006, states could waive these federal mileage requirements for those entities designated as *necessary providers*. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) eliminated this state authority. As of January 1, 2006, states are no longer permitted to designate a facility as a necessary provider CAH. Existing necessary providers were grandfathered under the MMA**.**

President's Proposal

The President's budget would rescind the CAH designation for those entities that are within 10 miles from another hospital or CAH, which would eliminate their Medicare cost-based payments (of 101%) beginning in FY2016. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $0.8 billion over the next 10 years.

Encourage Appropriate Use of Inpatient Rehabilitation Facilities

Current Law

Inpatient rehabilitation facilities (IRFs) are either freestanding hospitals or distinct units of other hospitals that are exempt from Medicare's inpatient PPS, which is used to pay acute care, general hospitals. Until recently, the Medicare statute gave the Secretary the discretion to establish the

criteria that facilities must meet to be considered IRFs. Since October 1, 1983, CMS has required that a facility must treat a certain proportion of patients with specified medical conditions to qualify as an IRF and receive higher Medicare payments. IRFs were required to meet the "75% rule," which determined whether a hospital or unit of a hospital qualified for the higher IRF payment rates or was paid as an acute care hospital. According to the rule, at least 75% of a facility's total inpatient population must be diagnosed with one of 13 preestablished medical conditions for that facility to be classified as an IRF. This minimum percentage is known as the compliance threshold. The rule was suspended temporarily and reissued in 2004 with a revised set of qualifying conditions and a transition period for the compliance threshold as follows: 50% from July 1, 2004, and before July 1, 2005; 60% from July 1, 2005, and before July 1, 2006; 65% from July 1, 2006, and before July 1, 2007, and 75% from July 1, 2007, and thereafter. During the transition period, secondary conditions (comorbidities) were to be considered as qualifying conditions. The DRA extended the 60% threshold an additional year beginning on July 1, 2006. As established by the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173), starting July 1, 2007, the IRF compliance threshold is set at 60% and comorbidities are included as qualifying conditions.

President's Proposal

The President's budget would reinstitute the 75% threshold, starting in FY2016. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $2.2 billion over the next 10 years.

Clarify the Medicare Fraction in the Medicare Disproportionate Share Hospital Statute

Current Law

Prior to FY2015, qualifying acute care hospitals received disproportionate share hospital (DSH) funds through an adjustment within the inpatient PPS. Generally, DSH hospitals received the additional payments based on their DSH patient percentage and the applicable formula established in statute. The formula has two components: (1) a Medicare fraction that has patient days provided to Medicare beneficiaries who qualify for Supplemental Security Income (SSI) divided by total Medicare inpatient days and (2) a Medicare fraction that has patient days provided to Medicaid beneficiaries divided by total hospital inpatient days. A few urban acute care hospitals receive DSH payments under an alternative formula. The Medicare DSH payment adjustment has been the subject of substantial litigation.

In FY2015, Medicare DSH funding to acute care hospitals changed. Qualifying inpatient PPS hospitals that get Medicare DSH funding receive 25% of the amount of DSH funds established by the existing DSH formula. The remaining DSH funds, reduced by the amount of the change in the uninsured from the enactment of the ACA and other ACA adjustments, are distributed to these qualifying DSH hospitals based on their share of uncompensated care. In FY2016, CMS is using a hospital's share of DSH patient days to approximate its share of uncompensated care. DSH patient days are those days provided to patients who are eligible for SSI and entitled to Medicare Part A benefits and those days provided to Medicaid patients.

President's Proposal

The President's budget would clarify that hospital days for beneficiaries who have exhausted their inpatient Medicare Part A benefits and who are enrolled in Medicare Advantage plans under Part C of Medicare are included in the Medicare fraction of hospitals' DSH formula. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Medicare Parts A and B

Implement Bundled Payment for Post-acute Care

Current Law

Post-acute care services primarily include nursing and rehabilitation services following a beneficiary's inpatient hospital stay. These services are provided in institutional settings, such as long term care hospitals (LTCHs), IRFs, and SNFs, as well as in community-settings by home health agencies (HHAs). Use of post-acute care services and the availability of post-acute care providers vary dramatically across states. The Institute of Medicine has noted that geographic variation in overall Medicare spending is heavily influenced by the use of post-acute care services, particularly SNFs and home health services. To encourage a more efficient use of post-acute care and improve care coordination, in 2008, MedPAC recommended that Congress should direct the Secretary to test bundled payments (single payments that cover the cost of an array of items and services) for post-acute care. Additionally, as required by the ACA, a demonstration project under way at the Innovation Center is testing bundled payments for post-acute care to demonstration participants.

President's Proposal

The President's budget would implement a bundled payment for post-acute care providers (LTCHs, IRFs, SNFs, and HHAs) beginning in FY2020. The bundled payment would be based on patient characteristics and other factors and be set to produce a total cumulative reduction in bundled payment rates of 2.85% by FY2022. Payments would be bundled for at least half of the total payments for post-acute care providers. Beneficiary cost-sharing structures would not change. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $9.3 billion over the next 10 years.

Allow CMS to Assign Beneficiaries to Federally Qualified Health Centers and Rural Health Clinics Participating in the Medicare Shared Savings Program

Current Law

The ACA created Accountable Care Organizations (ACOs) under the Medicare program to encourage coordinated care for beneficiaries, particularly those with chronic conditions. Ideally,

groups of doctors, hospitals, and other health care providers voluntarily organize into ACOs with the goal of delivering high-quality care to their Medicare patients in an efficient manner while avoiding unnecessary duplication of services and minimizing or preventing medical errors. If the providers can deliver care through the ACO such that Medicare spending is less than what the care would have been had the beneficiaries received services under the traditional fee-for-service Medicare program, the providers share in the achieved savings. Three models of ACOs exist under the Medicare program: (1) the Medicare Shared Savings Program, (2) Advance Payment ACO Models, and (3) Pioneer ACOs.[31]

Although the ACA did not define federally qualified health centers and rural health centers as ACO professionals, the law allowed the Secretary to include "other Medicare providers and suppliers as the Secretary determines appropriate." In subsequent regulations,[32] the Secretary used this authority to declare federally qualified health centers and rural health clinics eligible to participate independently in the Medicare Shared Savings Program.

President's Proposal

The President's budget "would allow the Secretary to assign more Medicare fee-for-service beneficiaries to Federally Qualified Health Centers and Rural Health Clinics that participate in an Accountable Care Organization under the Medicare Shared Savings Program." Although the President's budget states that this "proposal could result in assignment of a greater number of Medicare fee-for-service beneficiaries to Accountable Care Organizations," it gives no specifics on how this would increase assignment, as current regulations allow federally qualified health centers and rural health clinics to form independent ACOs. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would save $80 million over the next 10 years.

Expand Basis for Beneficiary Assignment for Accountable Care Organizations to Include Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists

Current Law

Unlike managed care plans, Medicare beneficiaries do not elect to enroll in a particular plan but are assigned to an ACO "based on their utilization of primary care services provided ... by a [Medicare] ACO professional."[33] Current law describes an ACO professional as a physician ("a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action") or a practitioner, including physician assistants, nurse practitioners, and clinical nurse specialists. However, in general, assignment to an ACO is

[31] For more detail on the different Accountable Care Organization (ACO) models, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/.

[32] HHS, "Medicare Shared Savings Program: Accountable Care Organizations; Final Rule," 76 *Federal Register* 67811, November 2, 2011, at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf.

[33] Ibid., p. 67851.

made based on physician-based primary care furnished to the beneficiary. (If a beneficiary receives no primary care services from any primary care physicians, other criteria are used.)

President's Proposal

The President's budget would allow the Secretary to base beneficiary assignment in the Medicare Shared Savings Program on a broader set of primary care providers including nurse practitioners, physician assistants and clinical nurse specialists. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would save $60 million over the next 10 years.

Allow Accountable Care Organizations to Pay Beneficiaries for Primary Care Visits up to the Applicable Medicare Cost-Sharing Amount

Current Law

In general, Medicare beneficiaries enrolled in Part B are required to pay a 20% coinsurance (in addition to an annual deductible and the monthly premium) for covered Medicare Part B services they receive. Prevention services are an exception to this rule and include several types of screening services, the "Welcome to Medicare" initial physical exam, and annual wellness visits. For those services, beneficiaries have no cost sharing.

President's Proposal

The President's budget would allow ACOs participating in two-sided risk models to pay beneficiaries for their cost-sharing portion of a primary care visit. The ACO would pay all or part of the coinsurance associated with primary care visits, including cases in which the beneficiary has supplemental insurance. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Implement Value-Based Purchasing for Additional Providers

Current Law

Under a value-based purchasing system, health care providers would be awarded with payments for the quality of care provided to Medicare beneficiaries. The intent is to give providers an increased incentive to focus on quality of care rather than quantity of care. Current value-based purchasing initiatives include the Hospital Value-Based Purchasing Program and the value-based physician payment modifier. The Protecting Access to Medicare Act (PAMA; P.L. 113-93) requires a SNF Value-Based Purchasing Program to be implemented on or before FY2019.

President's Proposal

The President's budget would require that value-based purchasing programs be implemented, beginning in CY2017, for several additional provider types, including HHAs, ambulatory surgical centers, hospital outpatient departments, and community mental health centers. Additionally, the SNF Value-Based Purchasing Program enacted by Congress would be implemented in FY2018. The proposal would require that at least 2% of payments beginning in CY2017 and at least 5% of payments beginning in CY2019 be tied to the quality and efficiency of care. *This proposal is a modification of a legislative proposal from the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Adjust Payment Updates for Certain Post-acute Care Providers

Current Law

Medicare payment amounts typically are updated each fiscal or calendar year to address potential yearly changes in the cost of health care items and services. MedPAC has found that Medicare payments generally exceed providers' costs for providing post-acute services. Each year, MedPAC makes recommendations for provider payment increases for the next fiscal or calendar year. In its March 2014 report, MedPAC recommended that the Medicare payment updates for SNFs, IRFs, LTCHs, and HHAs be eliminated for the upcoming year. The ACA reduced the annual update policy for these post-acute providers to include an adjustment to account for economy-wide productivity improvements that result in cost savings. The productivity adjustment for SNFs, IRFs, and LTCHs was implemented on October 1, 2011. The productivity adjustment for HHAs was implemented on January 1, 2015. The annual payment updates for IRFs, HHAs, and LTCHs are subject to other reductions as well. The amount and timing of such reductions vary by provider. Every type of post-acute provider may be subject to an update less than zero that would result in a lower payment rate than in the preceding year.

President's Proposal

The President's budget would implement additional payment update reductions for IRFs, LTCHs, and HHAs of 1.1 percentage points each year from 2016 through 2025. This proposal would establish a payment update floor of zero from 2016 through 2025—payment updates for these providers would not drop below zero due to the 1.1 percentage point reduction. The annual payment update for SNFs would be set at a -2.5% update in FY2016. The SNF payment update would gradually increase to a -0.97% update in FY2023. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $102.1 billion over the next 10 years.

Medicare Part B

Reform Medicare Physician Payments to Promote Participation in High-Quality and Efficient Health Care Delivery Systems

Current Law

Payments for physician and other practitioner services under Medicare Part B are based on fee-for-service rates as set by the Medicare physician fee schedule. Sustainable growth rate (SGR) is the statutory method for determining the annual updates to the Medicare physician fee schedule. Under the SGR formula, if expenditures over a period are less than the cumulative spending target for that period, the annual update is increased. However, if spending exceeds the cumulative spending target over a certain period, future updates are reduced to bring spending back in line with the target. In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (a price index of inputs required to produce physician services). Beginning in 2002, the actual expenditure exceeded allowed targets, and the discrepancy has grown with each year. However, with the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions.

Recent efforts to repeal and replace the SGR have included proposals to replace Medicare physician fee schedule fee-for-service payments, which incentivized increased volume of services while being indifferent to quality or value of care. The proposals would replace the current Medicare payment methodology with alternative payment models that attempt to reward quality and efficiency of care.

President's Proposal

The President's budget would "accelerate physician participation in high-quality and efficient health care delivery systems by repealing the SGR formula and reforming Medicare physician payments in a manner consistent with the reforms included in recent bipartisan, bicameral legislation." *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $44.0 billion over the next 10 years.

Encourage Efficient Care by Improving Incentives to Provide Care in the Most Appropriate Ambulatory Setting

Current Law

Medicare payment rates often vary for the same ambulatory services provided to similar patients in different settings, such as physicians' offices, hospital outpatient departments, and ambulatory surgical centers. CMS uses the Medicare physician fee schedule to pay for physician and other practitioner services; outpatient services provided by hospital outpatient departments are paid under the Medicare outpatient PPS, and those provided by ambulatory surgical centers are paid under its own PPS. Medicare makes two payments for services provided in hospital outpatient departments or ambulatory surgical centers: one to the physician for the professional services

under the physician fee schedule and one for the hospital outpatient department or ambulatory surgical centers facility fee under their respective PPS. These Medicare payments for services provided in hospital outpatient departments and ambulatory surgical centers generally are higher than Medicare payments for the same services provided in physician offices. In addition, beneficiary out-of-pocket costs generally are higher because beneficiaries are subject to cost sharing on both the professional fee and the facility fee. Hospitals are buying physician practices and turning them into provider-based clinics, which are paid in the same way as hospital outpatient departments, increasing total Medicare payments as well as beneficiary out-of-pocket costs.

President's Proposal

The President's budget would lower payments to off-campus hospital outpatient departments under Medicare's outpatient PPS to either the Medicare physician fee schedule payment or the rate for surgical procedures covered under the payment system for ambulatory surgical centers rate. The payment reductions would be phased in over a four-year period starting in CY2017. The Secretary would be given the authority to adjust payments in the event of beneficiary access problems. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would save $29.5 billion over the next 10 years.

Make Permanent the Medicare Primary Care Incentive Payment in a Budget-Neutral Manner

Current Law

Medicare pays physicians for covered services furnished to beneficiaries on the basis of the Medicare physician fee schedule. In certain circumstances, physicians receive an additional payment to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities, including demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas. The ACA established an additional 10% bonus on select evaluation and management (and general surgery) codes under the Medicare fee schedule for five years, beginning January 1, 2011. The bonus has been available to primary care practitioners who (1) are physicians who have a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine, or are nurse practitioners, clinical nurse specialists, or physician assistants; and (2) furnish 60% of their services in the designated primary care codes.

President's Proposal

The President's budget would make this 10% primary care bonus payment permanent, beginning CY2016, in a budget neutral manner within the Medicare physician fee schedule. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Exclude Certain Services from the In-Office Ancillary Services Exception

Current Law

The Ethics in Patient Referrals Act, commonly referred to as the *Stark law*[34] enacted limitations on physician self-referrals in 1989. The Stark law, as amended, and its implementing regulations prohibit certain physician self-referrals for designated health services [35] that may be paid for by Medicare or Medicaid. In its basic application, the Stark law provides that if a physician (or an immediate family member of a physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare or Medicaid. It also provides that the entity may not present (or cause to be presented) a claim to the federal health care program or bill to any individual or entity for designated health services furnished pursuant to a prohibited referral. Under one general exception to the Stark law, physicians and group practices are permitted to order and provide certain self-referred designated health services in their offices when they meet specific statutory requirements. Although the exception was intended to protect the convenience of patients and to allow patients to receive certain services during their doctor visits, concerns have been raised that it has the potential to promote the overuse of these services.

President's Proposal

Effective in 2017, the President's budget proposal would exclude radiation therapy, therapy services, advanced imaging, and anatomic pathology services from the in-office ancillary services exception to the Stark law, except when a practice is clinically integrated and required to demonstrate cost containment, as defined by the Secretary. *This proposal is a modification of a legislative proposal from the President's FY2015 budget.*

The Administration estimates this proposal would save $6 billion over the next 10 years.

Modify Reimbursement of Part B Drugs

Current Law

Medicare covers some drugs (including some biologics—drugs derived from living cells) under Medicare Part B, rather than under Medicare's Part D outpatient prescription drug benefit. Part B drugs are administered "incident to physician services." Providers purchase Part B drugs and bill Medicare when they administer the drugs to patients. Physicians and other providers receive two Medicare Part B drug payments: (1) for administration of the drug and (2) for purchasing and supplying the drug. Medicare reimburses providers for supplying most Part B drugs based on a formula of 106% of the drug's average sales price (ASP), regardless of providers' drug acquisition cost. CMS reimburses providers for brand-name biologic products at 106% of ASP. For biosimilar products (generic biologics), CMS pays providers 106% of the reference biologic drug's ASP, where the reference product is the brand-name biologic.

[34] 42 U.S.C. §1395nn.

[35] A list of designated health services can be found at 42 U.S.C. §1395nn(h)(6). Services include clinical laboratory services, radiology services, and inpatient and outpatient hospital services.

Providers negotiate with drug wholesalers and other entities to purchase Part B drugs. Higher volume Part B drug purchasers often can purchase Part B drugs at prices considerably below 106% of ASP, thereby earning profit each time they administer a drug. When ASP exceeds market prices, the Secretary has authority to substitute another payment methodology that would reduce reimbursement for Part B drugs. The HHS OIG has found that a number of Part B drugs' payment based on the 106% of ASP reimbursement methodology exceeded market prices. CMS published a final rule to substitute a lower Part B drug payment when market prices were lower than what Medicare was paying and began making the payment substitutions on January 1, 2013.

President's Proposal

Beginning in CY2016, the President's proposed budget would reduce Medicare Part B drug reimbursement from 106% of ASP to 103% of ASP, except when providers' drug acquisition costs are more than 103% of ASP. When providers' Part B drug acquisition costs exceed 103% of ASP, then drug manufacturers would be required to pay providers rebates that would reduce the cost to the provider to ASP plus 3% less a standard overhead fee to be determined by the Secretary. These Part B drug rebates would be excluded from ASP calculations. Using a percentage based on the ASP plus 3% formula, the Secretary also would be given authority to substitute a budget-neutral flat fee to pay a portion of or the total amount that exceeded ASP. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $7.4 billion over the next 10 years.

Modify the Documentation Requirement for Face-to-Face Encounters for Durable Medical Equipment Claims

Current Law

The ACA required that, beginning January 1, 2010, a physician must document that a physician, nurse practitioner, physician assistant, or clinical nurse specialist has had a face-to-face encounter with the patient during the six-month period prior to prescribing durable medical equipment (DME) under the Medicare program.

President's Proposal

The President's budget would modify the requirement by allowing certain nonphysician practitioners to document the face-to-face encounter. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Expand Coverage of Dialysis Services for Beneficiaries with Acute Kidney Injury

Current Law

Individuals diagnosed with end-stage renal disease (ESRD; i.e., permanent kidney failure) generally are entitled to Medicare and able to receive coverage for routine dialysis, a process of filtering an individual's blood that is otherwise performed by functioning kidneys, as well as for other medical benefits in the Medicare program. Medicare will provide payment for beneficiaries with ESRD that receive routine dialysis in an ESRD facility but typically will not provide payment for beneficiaries with ESRD that receive dialysis treatment in a hospital outpatient department. In contrast, Medicare cannot provide payment to ESRD facilities for acute dialysis, that is, nonroutine, short-term dialysis for individuals who have acute kidney injury and do not have ESRD. Individuals with acute kidney injury must receive acute dialysis in available hospital outpatient departments for Medicare to cover the service.

President's Proposal

The President's budget would allow Medicare payment to be made to ESRD facilities to cover short-term dialysis treatment of individuals with acute kidney injury. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would save $0.2 billion over the next 10 years.

Medicare Advantage

Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids

Current Law

Medicare Advantage (MA or Part C) is an alternative to original fee-for-service Medicare wherein beneficiaries can receive all Medicare-covered benefits (except hospice) through a private health plan. Under MA, employers and unions may sponsor MA plans for their Medicare-eligible employees, retirees, and/or their Medicare-eligible spouses and dependents. The Secretary has statutory authority to waive or modify requirements that may hinder the design, offering, or enrollment in these plans, which are referred to as Employer Group Waiver Plans. Like other MA plans, the Employer Group Waiver Plans are paid a per person monthly amount to provide all Medicare-covered benefits except hospice, and the method for determining the payment is the same for all Employer Group Waiver Plans and non-Employer Group Waiver Plans. Payments to MA plans are based on a comparison of each plan's estimated cost of providing Medicare covered services (a *bid*) relative to the maximum amount the federal government will pay for providing those services in the plan's service area (a *benchmark*). If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate. Starting in 2012, the size of the rebate is dependent on plan quality, ranging from 50% to 70% of the difference between the bid and the benchmark. The rebate must be returned to enrollees in the form of additional benefits, reduced cost sharing, reduced Part B or Part D premiums, or some combination of these. If a plan's bid is equal to or

above the benchmark, its payment is the benchmark amount and each enrollee in the plan pays an additional premium that is equal to the amount by which the bid exceeds the benchmark. Employer Group Waiver Plans tend to bid closer to the benchmark relative to the bids of non-Employer Group Waiver Plans because Employer Group Waiver Plans do not compete for enrollment and, therefore, have no incentive to bid below the benchmark.

President's Proposal

The President's budget would establish payment amounts for Employer Group Waiver Plans based on average non-Employer Group Waiver Plans' MA plan bids in each individual market beginning in CY2017 instead of a payment based on the Employer Group Waiver Plans' own bids. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $7.2 billion over the next 10 years.

Increase the Minimum Medicare Advantage Coding Intensity Adjustment

Current Law

MA plans are paid a per person monthly amount to provide the covered benefits to enrolled beneficiaries. In general, MA payments are risk adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries and thus discourage plans from preferential enrollment of healthier individuals. The risk scores for each MA enrollee are based on the diagnoses identified by the enrollee's doctors and submitted to the MA plan, which then submits them to CMS to be used to adjust the base payment for the plan enrollee. The risk adjustment model that is used to determine the relative cost of various disease categories (called *condition categories*) and thus the adjustment to the unadjusted plan payment is based on diagnoses collected from billing information for beneficiaries in original Medicare. In part because some medical providers serving beneficiaries in original Medicare are paid based on the services they provide rather than the diagnoses of the beneficiary, there tend to be differences between the completeness of diagnosis data collected for beneficiaries in original Medicare compared with data collected for those enrolled in MA.

The DRA required the Secretary to adjust MA risk scores for patterns of diagnosis coding differences between MA plans and providers under Parts A and B of Medicare for plan payments in 2008, 2009, and 2010. The ACA required the Secretary to conduct further analyses on the differences in coding patterns and adjust for those differences after 2010. Starting in 2014, the ACA specified minimum coding intensity adjustments, which were subsequently amended by the American Taxpayer Relief Act of 2012 (P.L. 112-240). In 2014, the coding intensity adjustment was the value of the adjustment in 2010 plus 1.5 percentage points; for 2015-2018, the adjustment is to be not less than the adjustment for the previous year increased by 0.25 percentage points; and starting in 2019, the coding intensity adjustment is to be not less than 5.9%. The minimum required adjustments are to be applied to risk scores until the Secretary implements risk adjustment using MA diagnostic, cost, and use data.

President's Proposal

The President's budget would increase the minimum coding intensity adjustment; starting in CY2017, the yearly increase to the minimum coding intensity adjustment would be raised from the current law level of 0.25 percentage points to 0.67 percentage points until the minimum adjustment reached an 8.76% adjustment in 2021. It would be held at that level thereafter. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $36.2 billion over the next 10 years.

Allow for Federal/State Coordinated Review of Duals Special Need Plan Marketing Materials

Current Law

Section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) established MA plans to provide coordinated care for individuals with special needs. MA special needs plans are permitted to target enrollment to one or more type of individual with special needs, including beneficiaries who (1) are institutionalized, (2) are eligible for Medicare and Medicaid (i.e., dual-eligible beneficiaries), and/or (3) have severe or disabling chronic conditions. In general, special needs plans are required to meet all statutory and regulatory requirements that apply to MA plans. CMS is required to review MA plan marketing materials for accuracy, content, and other requirements. For duals special needs plans, because the marketing materials are sent to Medicaid beneficiaries, state Medicaid agencies are also required to conduct a separate review to determine if the materials comply with different Medicaid rules and regulations. To integrate Medicare and Medicaid programs benefits more effectively and improve coordination between the federal government and states to ensure that dual-eligible beneficiaries get access to the items and services to which they are entitled, the ACA established the Federal Coordinated Health Care Office (also known as the Medicare-Medicaid Coordination Office) within CMS.

President's Proposal

This proposal would authorize the Secretary to permit CMS to conduct a coordinated review of duals special needs plan marketing materials provided to dual-eligible beneficiaries. Coordinated MA plan marketing material review with a unified set of standards could reduce the administrative burden on states and CMS while also potentially improving the marketing material quality. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Medicare Part D

Establish Quality Bonus Payments for High-Performing Part D Plans

Current Law

CMS uses a star ratings system to assess the quality of Part D stand-alone prescription drug plans (PDP) and MA plans with a prescription drug component (MA-PD). PDP sponsors are rated on up to 15 quality and performance measures, whereas MA-PD plan sponsors are evaluated on up to 48 measures. A 5-star rating is excellent; a 4-star rating is above average; a 3-star rating is average; a 2-star rating is below average; and a 1-star rating is poor. The average PDP star rating (weighted by enrollment) is 3.75 stars for 2015.[36] About 51% of PDPs have a 2015 rating of 4 stars or more, accounting for about 53% of PDP enrollment. The average star rating for MA-PDs (weighted by enrollment) is 3.92 stars in 2015. About 40% of MA-PDs have a 2015 ranking of 4 stars or more, accounting for about 60% of MA-PD enrollees.

President's Proposal

The President's budget would allow CMS to revise the Part D payment system to reimburse PDPs and MA-PDs based on their star rating. Plans earning four stars or more would have a larger portion of their costs reimbursed by CMS, and plans with ratings below four stars would receive a smaller subsidy. The proposal is based on a similar MA quality bonus payment program. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries

Current Law

Medicare Part D provides coverage of outpatient prescription drugs to beneficiaries who choose to enroll in this optional benefit. About 69% of eligible Medicare beneficiaries are enrolled in Part D.[37] Beneficiaries with limited income and resources may qualify for the low-income subsidy (LIS), which provides assistance with their Part D premiums, cost sharing, and other out-of-pocket expenses. In 2014 an estimated 11.5 million Medicare beneficiaries, 30% of Part D enrollees, qualified for low-income subsidies.[38] Medicare beneficiaries who qualify for Medicaid

[36] CMS, "Fact Sheet - 2015 Star Ratings." Available at CMS webpage "Part C & D Performance Data" in 2015 Star Ratings Technical Notes zip file, at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

[37] Shinobu Suzuki and Rachel Schmidt, MedPAC, "Status Report on Part D," January 15, 2015, at http://www.medpac.gov/-research-areas-/drugs-devices-tests.

[38] Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 28, 2014, Table IV.B7,http://www.cms.gov/Research-Statistics-Data-and-Systems/ (continued...)

based on their income and assets (dual-eligible beneficiaries), who are recipients of Medicare Savings Programs, or who receive SSI, automatically are eligible for the full LIS. Others who do not qualify for one of the above but have limited assets and incomes below 150% of the federal poverty level (FPL) also may be eligible for the LIS and receive assistance for some portion of their premium and cost-sharing charges.

Prescription drug coverage is provided through PDPs, which offer only prescription drug coverage, or through MA-PDs, which offer prescription drug coverage that is integrated with the health coverage provided under Part C. Part D plan sponsors determine payments for drugs and are expected to negotiate prices with drug manufacturers, which may involve an agreement from the manufacturer to provide a rebate. Annual price increases are limited to the rate of consumer inflation.

Under Medicaid, basic prescription drug rebates are determined by the larger of either a comparison of a drug's quarterly average manufacturers' price (AMP) with the best price for the same period or a flat percentage (23.1%) of the drug's quarterly AMP. The basic rebate percentage for multisource, non-innovator, and all other drugs is 13% of AMP.

President's Proposal

Beginning in CY2017, the President's budget would require drug manufacturers participating in Part D to pay the difference between rebates provided to Part D plans and the corresponding Medicaid rebate levels for brand name and generic drugs provided to LIS beneficiaries. Manufacturers would be required to provide an additional Part D rebate for brand-name and generic drugs when prices for the drugs rise faster than the rate of inflation. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $116.1 billion over the next 10 years.

Accelerate Manufacturer Discounts for Brand-Name Drugs to Provide Relief to Medicare Beneficiaries in the Coverage Gap

Current Law

The Medicare Part D standard drug benefit includes a coverage gap or "doughnut hole"—a period when enrollees who have reached the plan's initial coverage limit but have not yet spent enough to qualify for more generous catastrophic coverage—face higher out-of-pocket costs. In 2015, an enrollee in a standard plan pays a $320 deductible, and 25% coinsurance or co-payments on drug spending, up to the initial coverage limit of $2,960. Between $2,960 and the catastrophic threshold of $7,062.76—the current coverage gap—a beneficiary faces higher cost sharing.[39]

(...continued)

Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/TrusteesReports.html.

[39] For low-income subsidy (LIS) beneficiaries who are not eligible for manufacturer discounts on brand-name drugs in the coverage gap, the catastrophic threshold is $6,680.

Prior to the ACA, Part D enrollees who did not receive a low-income subsidy generally paid the full cost of drugs in the coverage gap. The ACA gradually phases out the coverage gap through a combination of manufacturer discounts on brand-name drugs and federal subsidies for brand-name and generic drugs. By 2020, enrollees in Part D standard plans will have a 25% cost share for all prescriptions from the time they meet the deductible until they reach the catastrophic limit, after which cost sharing is negligible.

In accordance with the ACA, manufacturers in 2011 began providing a 50% discount for brand-name drugs purchased in the coverage gap. From 2011 to 2020, the federal government is providing gradually increasing subsidies for brand-name and generic drugs. By 2020, the government will subsidize 25% of the cost of brand-name drugs (in addition to the manufacturer's 50% discount) and 75% of the cost of generic drugs in the coverage gap.

President's Proposal

The President's budget would increase the manufacturer discount for brand-name drugs to 75% from 50%, beginning in CY2017. The change would effectively eliminate the coverage gap for brand-name drugs in CY2017, though federal generic drug subsidies would continue to be phased in through CY2020. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $9.4 billion over the next 10 years.

Allow the Secretary to Negotiate Prices for Biologics and High-Cost Prescription Drugs

Current Law

Medicare Part D is designed as a market-oriented program, with private insurers submitting bids to CMS each year to provide a standard package of benefits or alternative coverage that is at least actuarially equivalent to a standard plan. Insurers compete for enrollees by offering lower prices or more generous benefits. Although all Part D insurers must meet certain minimum requirements, there can be significant differences among plans in terms of benefit design, specific drugs included in a formulary (i.e., list of covered drugs), and cost sharing for particular drugs. Part D plan sponsors negotiate rebates, discounts and other price reductions with pharmaceutical manufacturers. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which created Part D, prohibits the Secretary from interfering in negotiations between drug manufacturers and pharmacies and plan sponsors and from requiring a particular formulary or instituting a price structure for the reimbursement of covered Part D drugs.[40] In addition, CMS regulations[41] allow insurers offering Part D plans to place prescription drugs that cost $600 per month or more on a specialty price tier. To control usage or encourage use of less expensive medications, Part D sponsors may charge enrollees higher cost sharing for specialty-tier drugs than for other drugs—up to 33% of the price of a specialty-tier drug, depending on the specific plan design. Many of the drugs placed on Part D plan specialty tiers are biologics, which are complex drugs derived from living cells. There has been concern among Part D beneficiaries and

[40] Social Security Act, §1860D-11(i).

[41] 42 CFR 423.578(a)(7).

plan sponsors about the rising cost of specialty-tier drugs for treating certain diseases such as hepatitis and cancer. Only 0.25% of 2013 Medicare Part D claims were for specialty-tier drugs, but they accounted for 11% of Part D drug spending.[42]

President's Proposal

The President's budget recommends giving the Secretary authority to negotiate with manufacturers to determine Part D prices for biologics as well as for other high-cost drugs eligible to be placed on the specialty drug tier. As a condition of participating in Part D, pharmaceutical manufacturers would be required to supply HHS with all data and information necessary to come to a price agreement. Negotiated drug prices would be indexed to the consumer price index, meaning they would be allowed to rise only as fast as overall consumer inflation. Plan sponsors would be allowed to negotiate additional discounts off this price. HHS would monitor the pharmaceutical industry to ensure the changes did not lead to increased introduction of physician-administered drugs (which could be covered under Medicare Part B) or to excessive price inflation for Part D drugs already on the market. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Encourage the Use of Generic Drugs by Low-Income Beneficiaries

Current Law

LIS beneficiaries enrolled in Medicare Part D may qualify for additional assistance with some, or all, of their prescription drug cost sharing. LIS beneficiary cost sharing varies by income, and is adjusted annually.

For 2015,

- Dual-eligible beneficiaries (who qualify for both Medicare and Medicaid) who are institutionalized or are receiving home- and community-based services have no drug co-payments or coinsurance;
- Full-benefit, dual-eligible LIS beneficiaries with income below 100% of FPL have a co-payment of $1.20 for generic drugs and $3.60 for brand-name drugs, until they reach the catastrophic threshold, when their co-payment is zero;
- Full-benefit, dual-eligible LIS beneficiaries with income above 100% of FPL, and other LIS beneficiaries with incomes up to 135% of FPL and limited assets, pay $2.65 for a generic drug and $6.60 for a brand-name drug until they reach the catastrophic threshold, when their co-payment is zero.

[42] CMS, "Medicare Part D Specialty Tier," April 7, 2014, at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/SpecialtyTierMethodology.pdf. Although specialty drug claims have held steady as a proportion of all claims since 2011 (0.24%), they have assumed a larger share of program costs (rising from 8.5% in 2011 to 11.0% in 2013), reflecting price inflation or new drugs.

- Other beneficiaries with incomes up to 150% of FPL and limited assets pay a flat 15% coinsurance rate for all drugs up to the catastrophic threshold; cost sharing above that level is $2.65 for a generic drug or a preferred, multiple source drug and $6.60 for a brand-name drug.

LIS beneficiaries are more likely to have multiple, chronic ailments than other Part D beneficiaries, and they also are more likely to have higher drug costs. At the same time, a smaller share of LIS beneficiary prescriptions is filled with lower-cost, generic drugs, as compared with non-LIS beneficiaries. CMS data show that non-LIS enrollees had a generic dispensing rate of about 80% in 2011, compared with about 75% for LIS enrollees.[43] Part D plan sponsors often use incentives, such as higher co-payments for expensive drugs, to persuade enrollees to switch to cheaper generics. Because LIS beneficiaries pay a set amount, regardless of the price of a drug, such incentives may be less successful with the LIS population.

President's Proposal

The President's budget proposes reducing co-payments for generic drugs for LIS beneficiaries. At the same time, the proposal would increase co-payments for brand-name drugs to twice the level under current law. The Secretary would have authority to exclude brand-name drugs in therapeutic classes from the requirement to double co-payments if therapeutic substitution with another, lower-priced drug was not clinically appropriate or a generic substitute was not available. LIS beneficiaries could submit an appeal to continue buying brand-name drugs at current rates. The proposed cost-sharing change would not apply to LIS beneficiaries who are in an institution. Part D LIS beneficiaries with incomes between 135% and 150% of FPL would face higher cost sharing only if they reached their plan's catastrophic coverage limit. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $8.9 billion over the next 10 years.

Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries

Current Law

Generally, there is a two-step process for low-income persons to gain a low-income subsidy for their Part D coverage. First, a determination must be made that the individuals qualify for the assistance; second, the individuals must enroll, or be enrolled, in a specific Part D plan. Some LIS individuals who have not elected a Part D plan are enrolled into one automatically by CMS. CMS identifies plan sponsors offering basic prescription drug coverage with a premium at or below the Part D low-income premium subsidy amount, set annually through a formula. If more than one sponsor in a region meets the criteria, CMS auto-enrolls beneficiaries on a random basis among available plans. There is also a *facilitated enrollment* process for enrollees in Medicare Savings programs, SSI enrollees, and persons who applied for and were approved for low-income subsidy assistance. The basic features applicable to auto-enrollment are the same for facilitated enrollment.

[43] CMS, "2011 Medicare Part D Drug Utilization Trends," December 26, 2013, Slide 15, at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html.

President's Proposal

The President's budget would allow CMS to contract with a single Part D plan to provide coverage for LIS beneficiaries while their eligibility is being processed, rather than assigning these beneficiaries to plans through the current, random process, which would mean one plan would serve as the contact point for LIS beneficiaries who seek reimbursement for retroactive drug claims. CMS would pay the single plan through an alternative method. *This proposal was included in the President's FY2015 budget.* (This proposal affects both the Medicare and Medicaid budgets.)

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Establish Authority for a Program to Prevent Prescription Drug Abuse in Medicare Part D

Current Law

As part of overall efforts to prevent prescription drug abuse, HHS requires Part D sponsors to conduct drug utilization reviews, which can help to identify inappropriate or even illegal activity by an enrollee, prescriber, or pharmacy. The CMS Medicare Part D Overutilization Monitoring System tracks whether sponsors have adequate systems to identify beneficiaries who may be overutilizing prescribed drugs. CMS provides Part D sponsors with quarterly reports of beneficiaries identified as having potential overutilization issues. Plan sponsors must develop criteria to identify which beneficiaries should be subject to special case management.

President's Proposal

The President's budget would give the Secretary the authority to require that high-risk Medicare Part D beneficiaries use only certain prescribers and/or pharmacies to obtain controlled substances. The proposal is similar to restrictions already in place in many state Medicaid Programs. CMS would be required to ensure that Part D beneficiaries had continued reasonable access to services of "adequate" quality. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Require Mandatory Reporting of Other Prescription Drug Coverage

Current Law

Generally, Medicare is the *primary payer* for medical services, meaning that it pays health claims first. If a beneficiary has other health insurance, that insurance is billed after Medicare has made payments to fill possible gaps in Medicare coverage. In certain situations, however, federal Medicare Secondary Payer laws prohibit Medicare from making payments when payment has been made, or can reasonably be expected to be made, by another insurer such as an employer-sponsored group health plan. To identify cases where Medicare is the secondary payer, HHS

matches information about Medicare recipients against data from the Social Security Administration and Internal Revenue Service. The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires private insurers such as group health plans, liability insurers, no-fault insurers, and workers' compensation plans to submit coverage information regularly to HHS regarding Medicare beneficiaries. Even though Medicare Secondary Payer laws require that employer- and union-sponsored health plans report enrollment information to HHS, other group health plans are not required to inform HHS or Part D plan sponsors that they provide drug benefits to enrollees.

President's Proposal

The President's budget would extend mandatory Medicare Secondary Payer reporting to prescription drug coverage in an effort to ensure that all drug coverage that is primary to Medicare is communicated to HHS and to Part D sponsors, thereby permitting sponsors to comply with Medicare Secondary Payer requirements. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would save $0.5 billion over the next 10 years.

Suspend Coverage and Payment for Questionable Part D Prescriptions and Incomplete Clinical Information

Current Law

Recent investigations of the Part D program, including a 2011 Government Accountability Office (GAO) study, found that some beneficiaries had obtained overlapping prescriptions from multiple physicians for frequently abused prescription drugs.[44] CMS has taken several actions to reduce the potential for inappropriate utilization of Part D prescription drugs, with an emphasis on opioids and acetaminophen. CMS has instructed plan sponsors to institute controls at the point of sale to better control access to medications and to use quantity limits to guard against overutilization of drugs. Plan sponsors must institute closer reviews of filled prescriptions to identify at-risk beneficiaries and enter into case management with the beneficiaries' prescribers.

President's Proposal

This proposal would give the Secretary authority to suspend Part D coverage and payment for drugs prescribed by providers who mis-prescribe or overprescribe drugs that have the potential to be abused by beneficiaries. The Secretary would be allowed to suspend coverage and payment for Part D prescription drugs when the prescriptions present an imminent risk to patients. In addition, the proposal would allow the Secretary authority to require that providers include additional information on certain Part D prescriptions, such as diagnosis codes, to obtain coverage. *This proposal was included in the President's FY2015 budget.*

[44] Government Accountability Office, "Medicare Part D: Instances of Questionable Access to Prescription Drugs," September 2011, http://www.gao.gov/assets/590/585424.pdf.

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics

Current Law

The Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98-417, commonly known as the Hatch-Waxman Act) established the abbreviated new drug application path to Food and Drug Administration (FDA) marketing approval of a generic version of a drug after a brand-name product's patent has expired. An abbreviated new drug application allows a sponsor of a generic version of an FDA-approved drug to use, in the abbreviated new drug application, safety and effectiveness data that the brand-name firm had provided to the FDA in its new drug application. Because the generic sponsor, therefore, does not have to repeat all of the expensive and time-consuming clinical testing FDA requires in an original new drug application, generic prices generally are much lower than the brand-name product's price. The sponsor of a proposed generic product may challenge a brand-name manufacturer's patent by filing an abbreviated new drug application with a paragraph IV certification (that the patent is invalid or not infringed). The FDA provides to the first successful paragraph IV filer(s) a 180-day market exclusivity, not allowing another generic entry on the market during that period.

Brand-name and generic sponsors engaged in litigation within the Hatch-Waxman statutory framework sometimes conclude their litigation through settlement, rather than awaiting a formal decision from a court. In some settlements, the brand-name company pays the generic firm in exchange for the generic firm's agreement not to market the pharmaceutical. These arrangements have been termed *reverse* payments or *pay-for-delay* agreements.

President's Proposal

Beginning in 2016, this legislative proposal would authorize the Federal Trade Commission to prohibit pay-for-delay agreements between brand and generic pharmaceutical companies that delay entry of generic drugs and biologics into the market. *This proposal was included in the President's FY2015 budget.* (This proposal affects both the Medicare and Medicaid budgets.)

The Administration estimates this proposal would save Medicare $10.1 billion over the next 10 years.

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics

Current Law

The Biologics Price Competition and Innovation Act of 2009 (incorporated into the ACA) established a licensure pathway for competing versions of previously marketed biologics. In particular, the legislation created a regulatory regime for two types of follow-on biologics, termed

biosimilar and *interchangeable* biologics. It afforded the FDA a prominent role in determining the particular standards for biosimilarity and interchangeability for individual products.

In addition, the legislation created FDA-administered periods of data protection and marketing exclusivity for certain brand-name drugs and follow-on products. Brand-name biologic drugs receive four years of marketing exclusivity, during which time other companies are prevented from filing an application for approval of a follow-on product. Brand biologics also receive 12 years of data exclusivity, during which time the follow-on manufacturer cannot rely on the clinical data generated by the innovator firm in support of FDA approval of a competing version of the drug. Unlike market exclusivity, data protection does not block competitors that wish to develop their own clinical data in support of their application for marketing approval. In addition, the first applicants to establish that their product is interchangeable with the brand-name biologic are provided a term of marketing exclusivity.

President's Proposal

The President's budget would award brand biologics 7 years of data exclusivity rather than the current 12 years, and no additional exclusivity periods would be provided for "minor" changes in product formulations. The proposal also would modify how Part B pays for biosimilar and new biological products. For these products, reimbursement would be based on the weighted average sales price of the reference biological product and all of its biosimilars, plus 6%. *This proposal is a modification of a legislative proposal from the President's FY2015 budget.* (This proposal affects both the Medicare and Medicaid budgets.)

The Administration estimates this proposal would save $4.4 billion over the next 10 years.

Medicare Premiums and Cost Sharing

Increase Income-Related Premiums Under Medicare Parts B and D

Current Law

Most Medicare beneficiaries enrolled in Part B pay premiums, which are set by law at 25% of the program's estimated (projected) costs per aged enrollee (i.e., enrollees aged 65 or older). Since 2007, higher-income beneficiaries have paid a larger share of premiums—35%, 50%, 65%, or 80%, depending on income. In 2015, the income thresholds for those premium shares are $85,000, $107,000, $160,000, and $214,000, respectively, for single filers. (For married couples, the corresponding income thresholds are twice those values.) The ACA imposed similar income-related premiums for Part D beginning in 2011. In addition, the ACA suspended inflation indexing of income thresholds for Parts B and D through 2019 at 2010 levels. In 2015, fewer than 5% of Part B enrollees are expected to pay these higher income-related premiums.

President's Proposal

Beginning in CY2019, the President's budget would increase the applicable percentage of the program's cost per aged enrollee for higher-income beneficiaries to between 40% and 90%, replacing the current 35% to 80% range under current law. The proposal also would lower the highest income threshold and increase the number of high-income brackets from four to five. The

new income thresholds would be $85,000, $107,000, $133,500, $160,000, and $196,000, and the respective applicable cost percentages would be 40%, 52.5%, 65%, 77.5%, and 90%. The proposal also would further suspend inflation indexing of the income thresholds until 25% of beneficiaries under Parts B and D were subject to these premiums. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $66.4 billion over the next 10 years.

Modify the Part B Deductible for New Beneficiaries

Current Law

In addition to paying monthly premiums for Medicare Part B, Medicare beneficiaries pay certain out-of-pocket cost-sharing amounts for their Part B services including an annual deductible. Prior to 2003, the amount of the Part B deductible was set in statute. The Medicare Prescription Drug, Improvement, and Modernization Act set the 2005 deductible level at $110 and required that the deductible be increased each year by the annual percentage increase in the Part B expected per capita costs for enrollees aged 65 and older beginning with 2006 (rounded to the nearest $1). The 2015 Part B annual deductible is $147.

President's Proposal

The President's budget would increase the annual deductible by an additional $25 in calendar years 2019, 2021, and 2023 for new Medicare enrollees. Specifically, under this proposal there would be two categories of beneficiaries, and the members of one group would pay a different annual deductible amount than the members of the second. The first group, comprised of beneficiaries who enroll in Medicare prior to January 1, 2019, would not be affected by this proposal. The annual Part B deductible for members of this first group would continue to be adjusted each year according to the current methodology. The deductible for Medicare beneficiaries in the second group, that is, those who enroll in Medicare beginning on January 1, 2019, and thereafter, would pay deductibles that would be subject to both the annual adjustments based on expected costs (current method) plus an additional increase of $25 starting in 2019, another $25 increase in 2021, and a third $25 increase in 2023. For example, in a scenario under which the deductible amount remained the same through 2023 (unlikely), in 2023, new beneficiaries would pay a $75 higher deductible than those who had been enrolled in Medicare prior to 2019. However, because deductibles are expected to grow each year due to expected growth in annual per capita costs, the application of the annual growth rate adjustments to the incrementally larger deductible amounts would mean that the difference in deductible amounts paid by individuals in the two groups would likely be greater than $75. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $3.7 billion over the next 10 years.

Clarify Calculation of the Late Enrollment Penalty for Medicare Part B Premiums

Current Law

Most people who elect to participate in the Medicare Part B program pay a premium. Those who do not sign up for Part B when first eligible, or who drop it and then sign up again later, may have to pay a late enrollment penalty for as long as they are enrolled in Part B.[45] Monthly premiums may go up 10% for each full 12-month period that one could have had Part B but did not sign up for it. By law, a Social Security beneficiary who is also enrolled in Medicare Part B must have the Part B premium automatically deducted from his or her Social Security benefits. If the annual Social Security cost-of-living increase is not sufficient to cover the standard Medicare Part B premium increase, most beneficiaries are protected by a *hold-harmless* provision in the Social Security Act (§1839(f)). Specifically, if in a given year the increase in the standard Part B premium would cause a beneficiary's Social Security check to be less in dollar terms than it was the year before, then the Part B premium is reduced to ensure that the amount of the individual's Social Security check does not decline.

President's Proposal

The President's budget would clarify that the hold-harmless provision only applies to the annual increase in the standard Part B premium and that it does not apply to late enrollment penalties. This proposal is consistent with current CMS practice. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Introduce a Part B Premium Surcharge for New Beneficiaries Who Purchase Near First-Dollar Medigap Coverage

Current Law

Medigap is private health insurance that supplements Medicare coverage. It typically covers some or all of Medicare's deductibles and coinsurance, and it also may include additional items or services not covered by Medicare, such as coverage while traveling overseas. Medigap is available to Medicare beneficiaries who have fee-for-service Medicare Part A and voluntarily enroll in Medicare Part B by paying the monthly premium. Individuals who purchase Medigap must pay a monthly premium, which is set by the insurance company selling the policy. There are 10 standardized Medigap plans with varying levels of coverage. Two of the 10 standardized plans cover Parts A and B deductibles and coinsurance in full (i.e., offer *first-dollar* coverage). In 2013, about 66% of all Medigap enrollees were covered by one of these two plans.[46]

[45] For more information, see CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

[46] America's Health Insurance Plans, Center for Policy and Research, *Trends in Medigap Coverage and Enrollment, 2013*, November 2014, p. 7, at http://www.ahip.org/Epub/Trends-in-Medigap-Enrollment—and-Coverage-Options-2013/Trends-in-Medigap-Enrollment—and-Coverage-Options,-2013.aspx.

President's Proposal

The President's budget, beginning in 2019, would impose a Part B premium surcharge for new Medicare beneficiaries who select a Medigap plan with very low cost-sharing requirements. The surcharge would be equal to approximately 15% of the average Medigap premium (or about 30% of the Part B premium). *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $4.0 billion over the next 10 years.

Introduce Home Health Co-payments for New Beneficiaries

Current Law

For beneficiaries who are eligible for Medicare-covered home health care, Medicare provides payment for a 60-day episode of home health care under a prospective payment system. The 60-day episode covers in-home skilled nursing, physical and occupational therapy, medical social services, and aide visits as well as medical supplies. Medicare originally required a 20% coinsurance for home health services covered under Part B in addition to having met the annual Part B deductible; however, legislative changes eliminated Medicare cost sharing for home health services. There are currently no Medicare cost-sharing requirements for home health services; however, beneficiaries may be responsible for co-payments associated with Medicare-covered DME and osteoporosis drugs provided during a home health episode of care. In its March 2014 report, MedPAC recommended that Congress establish a per episode co-payment for home health episodes that are not preceded by hospitalization or post-acute care use.

President's Proposal

Beginning in CY2019, the President's budget would institute a $100 co-payment for new beneficiaries for each home health 60-day episode with five or more visits that is not preceded by a hospital or inpatient post-acute stay. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $830 million over the next 10 years.

Medicare Administrative Proposals

Strengthen the Independent Payment Advisory Board to Reduce Long-Term Drivers of Medicare Cost Growth

Current Law

The ACA established the Independent Payment Advisory Board (IPAB) to develop and submit detailed proposals to Congress and the President to reduce the growth rate of Medicare spending. Proposals will be required only in certain years when the CMS chief actuary determines that the projected Medicare per capita growth rate exceeds predetermined spending targets, and the proposals will have to meet specific savings targets. Recommendations made by the board automatically go into effect unless Congress enacts specific legislation to prevent their

implementation. The first year the board's proposals can take effect is 2015 (which ties to the 2013 determination year). For the first five years of implementation, the target growth rate will depend on changes in consumer price indices. However, beginning with the sixth year of implementation, the Medicare target per capita growth rate will be the projected five-year average percentage increase in nominal gross domestic product (GDP) per capita plus 1.0 percentage point. In its April 2013 and 2014 determinations (for implementation in 2015 and 2016), the CMS actuary noted that the conditions for activating the IPAB trigger would not be met for 2015 or 2016. Based on projections of the rate of growth in health care expenditures, the Congressional Budget Office has estimated that IPAB activity will not be triggered in any of the next 10 fiscal years.

President's Proposal

The President's budget would lower the target rate applicable beginning in 2018 from GDP per capita growth plus 1 percentage point to GDP per capita growth plus 0.5 percentage points. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $20.9 billion over the next 10 years.

Integrate Appeals Process for Medicare-Medicaid Enrollees

Current Law

The Medicare and Medicaid appeals processes for beneficiaries differ significantly, and even within Medicare the appeals process differs. Although the Medicare Parts A, B, C, and D appeals processes are conceptually similar, there is substantial variation that has the potential to confuse beneficiaries and increase administrative costs for providers and states. The difficulty in navigating the appeals processes may be more significant for dual-eligible beneficiaries, or low-income Medicare beneficiaries who also are eligible for Medicaid, because they need to navigate both systems.[47]

For dual-eligible beneficiaries, Medicaid pays after Medicare. As a result, if services are covered by Medicare, Medicare pays for the dual-eligible beneficiary's treatment first. Then, if Medicaid covers the services, Medicaid pays any remaining cost. If services are covered only by Medicaid, then Medicaid is the only and primary payer. However, dual-eligible beneficiaries sometimes are in the situation where coverage of an item or service under one program is possible only after the other program has denied coverage. Medicaid will cover some services (depending on the state) only after Medicare has denied coverage for the item or service and Medicare's noncoverage decision has been appealed. The Medicare and Medicaid appeals process interactions are important for dual-eligible beneficiaries because these beneficiaries may experience treatment delays or care interruptions while going through Medicare's appeal process. In addition, the interaction of the Medicare and Medicaid appeals processes can be expensive for both programs, potentially adding administrative costs and duplicative treatments.

[47] National Senior Citizens Law Center, Issue Brief, *Building an Integrated Appeals System for Dual Eligibles*, Issue Brief, October 2011, http://www.nsclc.org/wp-content/uploads/2011/10/Building-an-Integrated-Appeals-System-for-Duals.pdf.

President's Proposal

The President's budget would create an integrated Medicare and Medicaid appeals process for dual-eligible beneficiaries. *This proposal was included in the President's FY2015 budget.* **(**This proposal affects both the Medicare and Medicaid budgets.)

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Reform the Medicare Appeals Process

Current Law

When Medicare beneficiaries, providers, suppliers, and other parties, including state Medicaid agencies, are dissatisfied with a Medicare payment, eligibility, or coverage decision, they have the option to appeal that decision. There are five levels in the Medicare fee-for-service claims appeals process. Individuals and entities dissatisfied with CMS's decision at one level may appeal to the next level. At the first level, staffs of the Medicare administrative contactor who were not associated with the initial claim determination make a claim determination. The second level of review is conducted by an independent contractor. There is no claim-value threshold to appeal claims at the first two appeal levels. At the third level of appeal, administrative law judges review the claims; the amount in controversy at this level in CY2015 must total at least $150. Appellants have the right to a hearing before an administrative law judge and may submit new evidence; CMS, generally through contractors, also may choose to participate in administrative law judges' appeal hearings, which can include cross-examination of witnesses and submission of evidence. If a party to the administrative law judge hearing is dissatisfied with the administrative law judge's decision, the party may request a review by the Medicare Appeals Council administered by the HHS Departmental Appeals Board. There are no requirements regarding the amount of money in controversy at this fourth level of appeal. Finally, at the fifth level, a party may seek a judicial review in federal district court. At this level, the amount in controversy must be at least $1,460 in CY2015. (The minimum amount thresholds at the third and fifth level of appeals are recalculated each year.)

Under current law, no fees are levied when individuals and other entities file Medicare fee-for-service appeals or appeal to higher levels. The Office of Medicare Hearings and Appeals implemented a voluntary program that permitted appellants to consolidate claims and enabled the Secretary to propose settlements based on a sample of claims that was extrapolated to a larger group of disputed claims.

President's Proposal

The President's budget includes the following six proposals to reform the Medicare appeals process:

- **Establish a Refundable Filing Fee.** This proposal would institute a per-claim filing fee at each fee-for-service appeal level for providers, suppliers, and state Medicaid agencies, including those acting as beneficiary representatives. The filing fee would be refunded when appellants received fully favorable determinations. There would not be a filing fee for beneficiaries. This proposal

would enable HHS to invest revenue from filing fees in improvements that would reduce the Office of Medicare Hearings and Appeals appeal backlog. The Administration estimates that collections from the filing fee would be $4 million in FY2016.

- **Increase Minimum Amount in Controversy for Administrative Law Judge Adjudication of Claims to Equal Amount Required for Judicial Review.** This proposal would increase the amount-in-controversy minimum required for administrative law judge adjudication to the same amount in controversy required for federal district court adjudication ($1,460 in CY2015). The proposal would better align the value of the claims appealed to the administrative law judge appeal level with the cost to adjudicate those claims. Appeals not reaching the amount-in-controversy minimum would be adjudicated by a Medicare magistrate (see proposal below). The amount-in-controversy minimum for administrative law judge adjudication would be adjusted annually consistently with the federal district court amount in controversy.
- **Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount-in-Controversy Threshold.** This proposal would allow the Office of Medicare Hearings and Appeals to assign claim appeals when the claim value was below the federal district court minimum amount in controversy ($1,460 in CY2015) to attorney adjudicators. This proposal would allow the Office of Medicare Hearings and Appeals to assign higher amount in controversy and more complex appeal claims to administrative law judges, which would help the Office of Medicare Hearings and Appeals to reduce the appeal backlog and expedite future appeal processing.
- **Expedite Procedures for Claims with No Material Fact in Dispute.** This proposal would allow the Office of Medicare Hearings and Appeals to issue decisions without a hearing if there was agreement on the material facts of the appeal, such as appeals of claims in which Medicare does not cover a particular drug or device or if a finding in favor of the appellant would be outside an administrative law judge's authority.
- **Remand Appeals to the Redetermination Level with the Introduction of New Evidence.** This proposal would remand appeals to the first appeal level (redetermination) when new evidence was submitted for the record at the second or subsequent appeal levels. Exceptions may be made if evidence was provided to the lower-level adjudicator but erroneously omitted from the record or if an adjudicator denied an appeal on a new and different basis than was made at an earlier determination. This proposal would provide an incentive for appellants to include all evidence early in the appeals process and ensure the same record was considered at all appeal levels.
- **Sample and Consolidate Similar Claims for Administrative Efficiency.** This proposal would authorize the Secretary to use sampling and extrapolation to adjudicate claim appeals and to consolidate at all appeal levels similar appellant cases into a single administrative appeal. Entities that were appealing extrapolated overpayments or that had consolidated appeals previously would be required to file one appeal request for any remaining disputed claims.

These proposals were not included in the President's FY2015 budget.

The Administration estimates these proposals would have no budgetary impact over the next 10 years.

Provide Office of Medicare Hearings and Appeals and Departmental Appeals Board Authority to Use Recovery Audit Contractor Collections

Current Law

The Office of Medicare Hearings and Appeals' workload increased from 60,000 appeals in FY2011 to an estimated 516,000 appeals in FY2014. The Office of Medicare Hearings and Appeals' rapid workload increase was attributable to a number of factors, including increasing program integrity scrutiny, stricter interpretation of payment rules and requirements, and increasing Medicare enrollment. However, Medicare's fee-for-service Recovery Audit Contractor (RAC) program was responsible for many of the additional appeals, accounting for nearly 200,000 appeals in FY2014. RACs are responsible for reducing Medicare's fee-for-service improper payment rates by identifying over- and underpayments. RACs differ from other program integrity contractors in that they only are paid a percentage of the overpayments they recover from Medicare providers. The Secretary is authorized to retain a portion of RAC recoveries to be deposited in the program management account to administer the RAC program.

President's Proposal

The President's budget would expand the Secretary's authority to retain a portion of fee-for-service RAC overpayment recoveries to administer the RAC program, as well as to fund the administration of the RAC appeals at the Office of Medicare Hearings and Appeals and the HHS Departmental Appeals Board. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost Medicare $1.3 billion over the next 10 years.

Other Proposals

Expand Sharing Medicare Data with Qualified Entities

Current Law

The ACA includes a provision that allows CMS to make standardized extracts of Medicare Parts A, B, or D claims data available to qualified entities for the purpose of publishing reports evaluating the performance of providers of services and suppliers. The ACA also requires that qualified entities combine claims data from sources other than Medicare with the Medicare data when evaluating the performance of providers and suppliers.

President's Proposal

The President's budget would expand the scope of how qualified entities could use Medicare data beyond that of performance measurement. The proposal would allow qualified entities to use the

data for fraud prevention activities and for value-added analysis for physicians. Also, qualified entities would be able to release raw claims data, instead of simply summary reports, to interested Medicare providers for care coordination and practice improvement. This proposal would make claims data available to qualified entities for a fee equal to Medicare's cost of providing the data. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Extend the Qualified Individuals Program Through CY2016

Current Law

BBA97 required state Medicaid programs to pay Medicare Part B premiums for a new group of low-income Medicare beneficiaries—*qualifying individuals* (QIs)—whose income was between 120% and 135% of FPL. BBA97 also amended the Social Security Act to provide for Medicaid payment for QIs through an annual transfer from the Medicare Part B Trust Fund to be allocated to states. States (and the District of Columbia) receive 100% federal funding to pay QI's Medicare premiums up to the federal allocation, but they receive no additional matching beyond this annual allocation. In September 2014, approximately 499,700 QI Medicare beneficiaries received financial assistance from state Medicaid programs to pay their Part B premiums. The QI program has been reauthorized and funded a number of times since it was established by BBA97. Most recently, Section 201 of PAMA authorized the QI program through March 31, 2015, and appropriated $1.035 billion in funding.

President's Proposal

The President's budget would extend authorization and funding for the QI program through December 31, 2016. *This proposal was included in the President's FY2015 budget.* (This proposal affects both the Medicare and Medicaid budgets.)

The Administration estimates this proposal would cost $975 million over the next 10 years.

Create Pilot to Expand the Program of All-Inclusive Care for the Elderly Eligibility to Individuals Between the Ages of 21 and 55

Current Law

The Program of All-Inclusive Care for the Elderly (PACE) is an integrated care program that provides comprehensive long-term services and supports to individuals aged 55 and older who require an institutional level of care, many of whom are eligible for both Medicare and Medicaid and are known as dual-eligible beneficiaries. The PACE program was established in the Social Security Act in Section 1894 for Medicare and Section 1934 for Medicaid. Setting up a PACE program is optional for states under Medicaid. PACE providers receive capitated payments from both Medicaid and Medicare to cover an enrollee's benefits. In many cases, the PACE program enables enrollees to receive services through an adult day health center rather than through an institution such as a nursing facility.

President's Proposal

The President's budget would create a pilot demonstration in selected states to expand PACE eligibility to individuals who qualify and are 21 years old to 55 years old. *This proposal was included in the President's FY2015 budget.* (This proposal affects both the Medicare and Medicaid budgets.)

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Estimated Cost/Savings for Medicare Legislative Proposals

If implemented, these legislative proposals in Medicare are estimated to decrease Medicare outlays by a net of $2.4 billion in FY2016 and a cumulative $423.1 billion over the next 10 years. **Table 3** shows the estimated cost/savings for each legislative proposal in Medicare.

Table 3. Estimated Cost/Savings for Medicare Legislative Proposals Included in the President's FY2016 Budget Proposal

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Medicare Part A				
Establish a Hospital-Wide Readmissions Reduction Measure	N	—	—	—
Extend Accountability for Hospital-Acquired Conditions	N	—	—	—
Reduce Medicare Coverage of Bad Debts	R	-$370	-$10,530	-$31,080
Better Align Graduate Medical Education Payments with Patient Care Costs	R	-1,000	-6,700	-16,260
Eliminate the 190-Day Lifetime Limit on Inpatient Psychiatric Facility Services	N	400	2,150	5,000
Reduce Critical Access Hospital Reimbursements from 101% of Reasonable Costs to 100% of Reasonable Costs	R	-110	-710	-1,730
Prohibit Critical Access Hospital Designation for Facilities That Are Less Than 10 Miles from the Nearest Hospital	R	-50	-320	-770
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	R	-170	-1,010	-2,230
Clarify the Medicare Fraction in the Medicare DSH Statute	R	—	—	—
Medicare Parts A and B				
Implement Bundled Payment for Post-acute Care	R	—	-430	-9,260

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Allow CMS to Assign Beneficiaries to Federally Qualified Health Centers and Rural Health Clinics Participating in the Medicare Shared Savings Program	N	—	-20	-80
Expand Basis for Beneficiary Assignment for Accountable Care Organizations to Include Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists	N	—	-10	-60
Allow Accountable Care Organizations to Pay Beneficiaries for Primary Care Visits up to the Applicable Medicare Cost-Sharing Amount	N	—	—	—
Implement Value-Based Purchasing for Additional Providers	M	—	—	—
Adjust Payment Updates for Certain Post-acute Care Providers	R	-1,600	-25,170	-102,070
Medicare Part B				
Reform Medicare Physician Payments to Promote Participation in High-Quality and Efficient Health Care Delivery Systems	N	430	9,090	43,990
Encourage Efficient Care by Improving Incentives to Provide Care in the Most Appropriate Ambulatory Setting	N	—	-6,740	-29,500
Make Permanent the Medicare Primary Care Incentive Payment in a Budget-Neutral Manner	N	—	—	—
Exclude Certain Services from the In-Office Ancillary Services Exception	M	—	-2,120	-6,020
Modify Reimbursement of Part B Drugs	R	-320	-2,880	-7,380
Modify the Documentation Requirement for Face-to-Face Encounters for Durable Medical Equipment Claims	R	—	—	—
Expand Coverage of Dialysis Services for Beneficiaries with Acute Kidney Injury	N	-10	-90	-200
Medicare Advantage				
Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids	R	—	-2,730	-7,160
Increase the Minimum Medicare Advantage Coding Intensity Adjustment	R	—	-6,780	-36,240
Allow for Federal/State Coordinated Review of Duals Special Need Plan Marketing Materials	N	—	—	—
Medicare Part D				
Establish Quality Bonus Payments for High-Performing Part D Plans	R	—	—	—

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries	R	—	-32,790	-116,130
Accelerate Manufacturer Discounts for Brand-Name Drugs to Provide Relief to Medicare Beneficiaries in the Coverage Gap	R	—	-2,490	-9,430
Allow the Secretary to Negotiate Prices for Biologics and High-Cost Prescription Drugs	N	—	—	—
Encourage the Use of Generic Drugs by Low-Income Beneficiaries	R	—	-3,090	-8,860
Ensure Retroactive Part D Coverage of Newly-Eligible Low-Income Beneficiaries	R	—	—	—
Establish Authority for a Program to Prevent Prescription Drug Abuse in Medicare Part D	N	—	—	—
Require Mandatory Reporting of Other Prescription Drug Coverage	N	-10	-170	-480
Suspend Coverage and Payment for Questionable Part D Prescriptions and Incomplete Clinical Information	R	—	—	—
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics	R	-690	-4,070	-10,060
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics	M	—	-910	-4,400
Premiums and Cost Sharing				
Increase Income-Related Premiums Under Medicare Parts B and D	R	—	-7,880	-66,410
Modify the Part B Deductible for New Beneficiaries	R	—	-120	-3,740
Clarify Calculation of the Late Enrollment Penalty for Medicare Part B Premiums	N	—	—	—
Introduce a Part B Premium Surcharge for New Beneficiaries Who Purchase Near First-Dollar Medigap Coverage	R	—	-310	-3,970
Introduce Home Health Co-payments for New Beneficiaries	R	—	-70	-830
Administrative Proposals				
Strengthen the Independent Payment Advisory Board to Reduce Long-Term Drivers of Medicare Cost Growth	R	—	—	-20,879
Integrate Appeals Process for Medicare-Medicaid Enrollees	R	—	—	—
Reform the Medicare Appeals Process	N	—	—	—

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Provide Office of Medicare Hearings and Appeals and Departmental Appeals Board Authority to Use Recovery Audit Contractor Collections	N	127	635	1,270
Other Proposals				
Expand Sharing Medicare Data with Qualified Entities	R	—	—	—
Extend the Qualified Individuals Program Through CY2016	R	775	975	975
Create Pilot to Expand PACE Eligibility to Individuals Between the Ages of 21 and 55	R	—	—	—
Savings from Program Integrity Proposals[a]		140	1,038	2,559
Interactions[b]		45	1,782	18,348
Total Proposals Impacting Medicare[c]		**-2,413**	**-102,470**	**-423,087**

Source: Table created by CRS based on data from the HHS, *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Totals may not add due to rounding.

DSH: Disproportionate share hospital.

PACE: Program of All-Inclusive Care for the Elderly.

a. See "Program Integrity Legislative Proposals" for descriptions of the program integrity legislative proposals impacting Medicare.

b. Adjusts for savings realized through IPAB and other Medicare interactions.

c. Note that **Table 1** shows that Medicare legislative proposals would save $1.8 billion in FY2016 because it includes a legislative proposal from the "Program Management Legislative Proposals" section of this report. The $1.8 billion in savings includes $2.4 billion in savings from Medicare legislative proposals net of premiums and offsetting receipts, in addition to the cost of $0.6 billion for program management legislative proposals.

Medicaid Legislative Proposals

Medicaid Benefits

Expand State Flexibility to Provide Benchmark Benefit Packages

Current Law

As an alternative to traditional Medicaid benefits, DRA gave states the option to change their Medicaid benefit packages for certain populations. States were allowed to offer benefit packages

similar to certain types of commercial insurance, such as the Blue Cross Blue Shield plan available through the Federal Employees Health Benefits Program. These types of benefits were referred to as benchmark or benchmark-equivalent benefits under the DRA but are now more commonly referred to as alternative benefit plans. The state option to provide these benefits can be found in Section 1937 of the Social Security Act. Following passage of the ACA, alternative benefit plans are required to offer essential health benefits as defined in Section 1302 of the act.

Who can enroll in alternative benefit plan coverage depends on the individual's eligibility pathway into Medicaid and on state decisions. Under Section 1937 of the Social Security Act, states can choose whether to require enrollment in alternative benefit plan coverage for certain groups, with some limitations. For example, "full benefit eligible individuals" as defined under Section 1937(a)(2) of the Social Security Act can be required to enroll in alternative benefit plans, but individuals who are institutionalized or who are dually eligible for Medicare and Medicaid cannot be required to enroll. Individuals made eligible for Medicaid under Section 2001(a) of the ACA in states that have chosen to expand Medicaid must enroll in alternative benefit plan coverage, but individuals eligible under Section 2001(e) of the ACA, an optional expansion group defined as individuals who are under the age of 65 with income above 133% of FPL, cannot be required to enroll in alternative benefit plans.

President's Proposal

The President's budget would allow states to enroll non-elderly, nondisabled adults with income that exceeds 133% of FPL in alternative benefit plans. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Require Coverage of Early and Periodic Screening, Diagnostic, and Treatment for Children in Inpatient Psychiatric Treatment Facilities

Current Law

States have the option to provide inpatient psychiatric care for Medicaid enrollees aged 21 and younger. This benefit is sometimes referred to as "Psych under 21." Under this option, Medicaid enrollees aged 21 years and younger can receive inpatient psychiatric hospital services in three settings: psychiatric hospitals, psychiatric units in general hospitals, and psychiatric residential treatment facilities. CMS historically has prohibited states from claiming Medicaid expenditures under the inpatient psychiatric facility benefit unless the expenditures were made to qualified providers of such services. Since inpatient psychiatric facilities are not qualified providers for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that is a mandatory benefit for most Medicaid enrollees aged 21 and younger, children in inpatient psychiatric facilities do not receive that benefit. Under EPSDT, children receive well-child visits, immunizations, laboratory tests, and other screening services at regular intervals. In addition, medical care that is necessary to correct or ameliorate identified defects, physical and mental illness, and other conditions must be provided, including some services that states may not otherwise cover in their Medicaid programs.

President's Proposal

The President's budget would lift the exclusion of Medicaid enrollees aged 21 and younger in inpatient psychiatric treatment facilities from receiving EPSDT coverage. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $0.4 billion over the next 10 years.

Provide Home- and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities

Current Law

Psychiatric hospitals, psychiatric units in general hospitals, and psychiatric residential treatment facilities are the three settings in which Medicaid enrollees aged 21 years and younger can receive inpatient psychiatric hospital services. Of these three settings, psychiatric residential treatment facilities are the only setting that is not a qualified inpatient facility for the purposes of home- and community-based services (HCBS). For individuals to be eligible for a Section 1915(c) HCBS waiver, they need to require the level of care provided in hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities. Psychiatric residential treatment facilities are not recognized as hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities under the Medicaid statute. Therefore, states have been unable to use the 1915(c) waiver authority to provide home- and community-based alternatives to institutional care for children receiving care in psychiatric residential treatment facilities.

President's Proposal

The President's budget would add services in psychiatric residential treatment facilities to the list of qualified institutional benefits for 1915(c) waivers. Thus, it would extend coverage of HCBS under 1915(c) waivers to eligible individuals who meet the level of care need for services in psychiatric residential treatment facilities. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $1.6 billion over the next 10 years.

Require Full Coverage of Preventive Health and Tobacco-Cessation Services for Adults in Traditional Medicaid

Current Law

The ACA added Section 2713 to the Public Health Service Act. Section 2713 requires that health plans provide coverage of preventive services without any cost sharing (such as a co-payment, coinsurance, or deductible) when an enrollee obtains services in the plan's provider network, effective September 23, 2010. These preventive services include evidence-based items or services assigned a grade of A or B by the United States Preventive Services Task Force; routine immunizations for adults and children recommended by the Advisory Committee on

Immunization Practices of the Centers for Disease Control and Prevention; preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration; and preventive services for women provided for in guidelines supported by the Health Resources and Services Administration. The requirements in Section 2713 are applicable to group health plans or health insurance issuers offering group health insurance coverage.

Preventive services in Medicaid generally are optional for states with the exception of preventive services for children as part of EPSDT services. The ACA added other requirements for preventive services in Medicaid specific to pregnant women and adults. Section 4107 of the ACA requires that states provide comprehensive tobacco- cessation services for pregnant women, including counseling, without any cost sharing. The ACA also requires that the alternative benefit plans through which adults made eligible for Medicaid under the ACA will receive Medicaid coverage provide coverage of the preventive services described above in Section 2713 of the Public Health Service Act.

President's Proposal

The President's budget would require coverage of preventive health services as defined in Section 2713 of the Public Health Service Act for all adults enrolled in Medicaid. The proposal would also expand Section 4107 of the ACA (i.e., comprehensive tobacco-cessation services without cost sharing) to all Medicaid eligible populations. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $0.8 billion over the next 10 years.

Pilot Comprehensive Long-Term Care State Plan Option

Current Law

Medicaid law and other provisions in the Social Security Act, as amended, contain several authorities that permit states to offer long-term services and supports to individuals in need of long-term care. In general, Medicaid law provides states with two broad authorities, which either cover certain long-term services and supports as a benefit under the Medicaid state plan or cover home- and community-based long-term services and supports through a waiver program. States are required to offer certain Medicaid institutional services, such as nursing facility services. However, the majority of HCBS offerings are optional for states.[48]

President's Proposal

The President's budget proposes establishing a comprehensive long-term care state plan option under an eight-year pilot program for up to five states. The proposal would authorize participating states to provide home and community-based care at the nursing facility level of care. This

[48] For more information about Medicaid coverage of long-term services and supports, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by Kirsten J. Colello.

proposal's stated intention is to create equal access to HCBS and nursing facility services for Medicaid program participants. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $4.1 billion over the next 10 years.

Allow States to Develop Age-Specific Health Home Programs

Current Law

Section 2703 of the ACA created the option for states to establish health homes for Medicaid enrollees with chronic conditions through a state plan amendment, beginning January 1, 2011. States can receive 90% in federal Medicaid matching funds for the first eight fiscal quarters of their state plan amendment. *Health homes* are service delivery models designed to coordinate care for enrollees with chronic physical and mental health conditions. Section 2703 of the ACA defines a *chronic condition* as including but not limited to the following: a mental health condition, substance use disorder, asthma, diabetes, heart disease, and being overweight as evidenced by having a body mass index of over 25. Individuals eligible under Section 2703 are eligible for Medicaid in the state and have at least two chronic conditions; have one chronic condition and are at risk of a second chronic condition; or have one serious and persistent mental health condition. States must enroll all individuals that meet these criteria, according to what is known as the *comparability rule* under Section 1902(a)(10)(B) the Social Security Act.

President's Proposal

The President's budget would allow states to target their health homes established under Section 2703 to specific age groups. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $1.0 billion over the next 10 years.

Allow Full Medicaid Benefits to All Individuals in a Home- and Community-Based Services State Plan Option

Current Law

States may elect to provide the Section 1915(i) HCBS state plan option to medically needy individuals enrolled in Medicaid. Under current law, states may choose to follow institutional income and resource eligibility rules for the medically needy living in the community. This allows states to treat medically needy individuals as if they are living in institutions by not counting income and resources from a spouse or parent. However, when a state elects to apply institutional rules for the medically needy instead of community rules, medically needy enrollees only can receive Section 1915(i) HCBS and no other Medicaid services.

President's Proposal

The President's budget would provide states with the option to offer full Medicaid state plan benefits to medically needy individuals who access HCBS through the Section 1915(i) state plan optional benefit. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $38 million over the next 10 years.

Expand Eligibility Under the Community First Choice Option

Current Law

The Community First Choice option allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit and to receive an increased federal medical assistance percentage rate of six percentage points. To be eligible, enrollees must be (1) eligible for Medicaid under an existing eligibility pathway that offers state plan services; (2) in an eligibility group under the state plan that covers nursing facility services or, if not in such a group, have income at or below 150% of FPL; and (3) meet institutional level-of-care criteria. Individuals also may be eligible for Community First Choice services under a Section 1915(c) HCBS waiver. One optional eligibility pathway, the Special Income Rule, allows states to extend Medicaid coverage to individuals in nursing facilities or other institutions with higher levels of income (up to 300% of the maximum SSI benefit). Under current law, states can extend the Community First Choice option to individuals with higher incomes only if they offer either the optional Special Income Rule eligibility pathway or a Section 1915(c) HCBS waiver that includes the special income group.

President's Proposal

The President's budget would provide states with the option to make Community First Choice services available to individuals who would be Medicaid eligible under the state plan if they were in a nursing facility. This proposal could reduce the need for states to offer a Section 1915(c) HCBS waiver to provide Community First Choice services to Medicaid enrollees with higher levels of income. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $3.6 billion over the next 10 years.

Expand Eligibility for the 1915(i) Home- and Community-Based Services State Plan Option

Current Law

Section 1915(i) of the Social Security Act allows states to offer HCBS under the Medicaid state plan without obtaining a Secretary-approved waiver. To be eligible, Medicaid enrollees' incomes must be less than or equal to 150% of FPL. In addition, they must have a level-of-care need that is less than the level of care required in an institution. States may extend eligibility to enrollees with incomes up to 300% of the maximum SSI benefit for those eligible for HCBS under waiver programs (i.e., Section 1115 of the Social Security Act or Sections 1915(c), (d) or (e) of the Social Security Act). For eligible enrollees who meet the higher financial eligibility threshold and waiver criteria, their level-of-care need may have to meet the level of care provided in an institution.

President's Proposal

The President's budget proposes to expand Medicaid eligibility under the Section 1915(i) HCBS state plan option by removing the requirement that individuals under the higher financial-eligibility threshold also be eligible under a waiver program. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $1.3 billion over the next 10 years.

Medicaid Coverage

Extend the Transitional Medical Assistance Program Through CY2016

Current Law

States are required to continue Medicaid benefits for certain low-income families that would otherwise lose coverage because of changes in their income.[49] This continuation of benefits is known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families that lose Medicaid eligibility due to (1) increased spousal support collections, or (2) an increase in earned income or hours of employment. Congress expanded work-related TMA benefits in 1988, requiring states to provide at least 6, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families that lose eligibility due to the loss of a time-limited earned-income disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time). Congress created an additional work-related TMA option in the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5). Under the ARRA option, states may choose to provide work-related TMA for a full 12-month period rather than two 6-month periods and may waive the requirement that the family must have received Medicaid in at least 3 of 6 months preceding the month in which eligibility is lost. Congress has acted on numerous occasions to extend these expanded TMA requirements (which are outlined in Sections 1902(e)(1) and 1925 of the Social Security Act) beyond their original sunset date of September 30, 1998. Most recently, PAMA extended the authorization and funding of expanded TMA requirements through March 31, 2015.

President's Proposal

The President's budget would extend the TMA program through December 31, 2016, and would permit states that adopt the ACA Medicaid expansion to opt out of TMA. The provision would also clarify that states are permitted to determine income eligibility for TMA based on modified adjusted gross income. *This proposal is a modification of a legislative proposal from the President's FY2015 budget.*

[49]Under the ACA, states are required to transition to a new income-counting rule based on modified adjusted gross income to establish uniform standards for what income to include or disregard in determining Medicaid eligibility for most non-elderly and nondisabled individuals, children under the age of 18, and adults and pregnant women under the age of 65, beginning January 1, 2014. With the transition to modified adjusted gross income, the extension of transitional medical assistance eligibility for individuals losing coverage under Section 1931 due to increased child support will no longer be relevant, as child support is not counted as income under modified adjusted gross income-based methodologies.

The Administration estimates this proposal would cost $1.8 billion over the next 10 years.

Permanently Extend "Express Lane" Eligibility Option for Children

Current Law

The Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3) of 2009 created a state plan option for "Express Lane" eligibility available to states through September 30, 2013. Under this option, states are permitted to rely on a finding from specified Express Lane agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and the Supplemental Nutrition Assistance Program) for (1) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility, (2) eligibility redeterminations, or (3) renewal of eligibility for medical assistance under Medicaid or CHIP. PAMA permits states to rely on Express Lane findings for child eligibility determinations through September 30, 2015.

President's Proposal

The President's budget would allow for a permanent extension of the state option to rely on "Express Lane" eligibility determinations for Medicaid and CHIP-eligible children. *This proposal was included in the President's FY2015 budget.* (This proposal affects both the Medicaid and CHIP budgets.)

The Administration estimates this proposal would cost $0.7 billion over the next 10 years.[50]

Allow Pregnant Women Choice of Medicaid Eligibility Category

Current Law

Under current law, states must cover pregnant women with annual income less than 133% of FPL based on modified adjusted gross income. Benefit coverage is limited to pregnancy and 60 days of postpartum coverage, and it may be limited to services that are related to pregnancy and other conditions that may complicate pregnancy. However, some states offer enhanced pregnancy services through their pregnancy-specific eligibility pathways, and federal regulations give states the option to provide low-income pregnant women with all Medicaid services that are covered under the state plan for other categorically needy beneficiaries.

Under the ACA, states have the option to expand Medicaid eligibility starting on January 1, 2014, to individuals under the age of 65 who are not pregnant who are otherwise not eligible for Medicaid, and who have income at or below 133% of FPL (effectively 138% of FPL, with the 5% income disregard included in the law). Although women who are pregnant at the time of their Medicaid eligibility determination must be enrolled through one of Medicaid's pregnancy-related eligibility pathways, Medicaid regulations specify that states are not required to track the pregnancy status of women eligible through the ACA Medicaid expansion group (or any other

[50] The President's budget estimate for this proposal includes impacts on CHIP for a total cost of $1.2 billion over 10 years.

Medicaid eligibility group). Individuals eligible through the ACA Medicaid expansion receive coverage through Medicaid alternative benefit plans. Alternative benefit plans must cover at least the 10 essential health benefits that also apply to the qualified health plans offered in the health insurance exchanges, and they must include maternity and newborn care. Under Medicaid regulations, women enrolled in the ACA Medicaid expansion group who become pregnant may request to be moved to the Medicaid mandatory coverage category, or they must stay in the ACA Medicaid expansion group. As a result of these program rules and regulations, women who are eligible only for pregnancy-related services may receive less generous benefits than others in their income group based on their pregnancy status.

President's Proposal

The President's budget would allow Medicaid enrollees who are pregnant to choose the eligibility category most suited to their needs. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Create State Option to Provide 12-Month Continuous Medicaid Eligibility for Adults

Current Law

Under current law, Medicaid and CHIP enrollees generally are required to report changes that may impact their eligibility status (e.g., changes in family income and/or composition). However, states may choose to extend coverage for a period of 12 months to Medicaid-eligible children, regardless of changes in annual income. This policy is known as *12-month continuous eligibility*. Even within that 12-month period, there are some circumstances that may prompt an eligibility redetermination, such as when a child ages out of a given eligibility category. Although no explicit statutory authority for 12-month continuous eligibility exists in CHIP, a number of states also extend this policy to children eligible under separate CHIP programs.

President's Proposal

The President's budget would extend the state option for 12 months of continuous eligibility to all Medicaid-eligible adults or, at state option, to adults determined eligible for Medicaid based on modified adjusted gross income rules. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $27.7 billion over the next 10 years.[51]

[51] The President's budget estimate for this proposal includes savings of $23.0 billion for subsidies in the health insurance exchanges for people who would have received coverage without 12-month continuous Medicaid eligibility. The net cost of this proposal is estimated to be $4.7 billion over 10 years.

Medicaid Payments

Rebase Future Medicaid Disproportionate Share Hospital Allotments

Current Law

Under federal law, states are required to make Medicaid DSH payments to hospitals treating large numbers of low-income and Medicaid patients. States receive federal matching funds for making DSH payments, up to a capped federal allotment that generally equals the previous year's allotment increased by the percentage change in the consumer price index for all urban consumers. In FY2014, federal Medicaid DSH allotments to states totaled $11.7 billion. The ACA required the Secretary to make aggregate reductions in Medicaid DSH allotments for each year from FY2014 to FY2020. Since the ACA, three laws have amended the ACA DSH reductions. Under current law, Medicaid DSH allotment reductions are to begin in FY2017 and end in FY2024. In FY2025, states' Medicaid DSH allotments are to rebound to their pre-ACA reduced levels with annual inflation adjustments for FY2016 through FY2025.

President's Proposal

Instead of having the Medicaid DSH allotments rebound to their pre-ACA reduced levels, the President's budget proposes to extend the ACA-reduced Medicaid DSH allotment levels to FY2025 and subsequent years. The FY2025 Medicaid DSH allotments would be each state's FY2024 allotment increased by the percentage change in the consumer price index for all urban consumers, and the allotments for subsequent years would be the previous year's allotment increased by the percentage change in the consumer price index for all urban consumers. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $3.3 billion over the next 10 years.

Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates

Current Law

States generally are free to set payment rates for items and services provided under Medicaid as they see fit, subject to certain exceptions and a general requirement that payment policies are consistent with efficiency, economy, and quality of care and are sufficient to provide access equivalent to the general population's access. Providers for which federal upper payment limits apply under Medicaid include hospitals and nursing facilities. Federal regulations specify that states cannot pay more in the aggregate for inpatient hospital services or nursing facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. No upper payment limit currently applies to durable medical equipment (DME) under Medicaid.

Historically, Medicare has paid for most DME on the basis of fee schedules. Unless otherwise specified by Congress, fee schedule amounts are updated each year by a measure of price inflation. The Medicare Prescription Drug, Improvement, and Modernization Act established a

Medicare competitive acquisition program (i.e., competitive bidding) under which prices for selected DME sold in specified areas would be determined not by a fee schedule but by suppliers' bids.

President's Proposal

The President's budget would limit federal reimbursement for a state's Medicaid spending on certain DME to what Medicare would have paid in the same state for the services. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $4.3 billion over the next 10 years.

Extend the Medicaid Primary Care Payment Increase Through CY2016 and Include Additional Providers

Current Law

For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be sufficient to enlist enough providers so that covered benefits are available to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area. Low Medicaid physician payment rates in many states and their impact on provider participation have been perennial concerns for policymakers. The ACA required that Medicaid payment rates for certain primary care services be raised to what Medicare paid for these services for CY2013 and CY2014. Physicians in subspecialties of family medicine, general internal medicine, and pediatrics were eligible to receive the increased primary care rates for certain primary care services. The federal government paid the entire cost of the increased primary care rates (i.e., the difference between Medicare payment rates and the Medicaid payment rates as of July 1, 2009) for those two calendar years. On December 31, 2014, the ACA requirement for enhanced primary care rates and the 100% federal financing of that requirement expired.

President's Proposal

The President's budget would extend the enhanced primary care rates through December 31, 2016. In addition, the budget proposal would expand the providers eligible for the enhanced primary care rates to obstetricians, gynecologists, and nonphysician practitioners (such as physician assistants and nurse practitioners). Under this proposal, primary care services provided in an emergency room would be excluded from the enhanced primary care rates. *This proposal is a modification of a legislative proposal from the President's FY2015 budget.*

The Administration estimates this proposal would cost $6.3 billion over the next 10 years.

Medicaid Prescription Drugs

Lower Medicaid Drug Costs and Strengthen the Medicaid Drug Rebate Program

Current Law

For drug manufacturers to sell their products to state Medicaid programs, they must agree to the conditions of the Medicaid Drug Rebate program. Among other drug rebate requirements, drug manufacturers must pay state Medicaid programs rebates on covered outpatient drugs and report certain drug pricing information, such as their best price for selected drugs. Drug manufacturers may dispute state drug rebate claims as far back as 1991. With certain exceptions, federal Medicaid law requires states participating in the Medicaid rebate program to cover all outpatient drugs offered by drug manufacturers that have signed drug pricing agreements with the Secretary. Prenatal vitamins and fluorides are included in the rebate program. Through unadvertised emergency-supply programs, some drug manufacturers provide certain patients with free medication.

For the purpose of determining prescription drug rebates, Medicaid distinguishes between two types of drugs: (1) single source drugs (generally, those still under patent) and innovator multiple source drugs (drugs originally marketed under a patent or an original new drug application but for which generic equivalents now are available); and (2) all other, non-innovator, multiple source drugs.[52] Rebates for the first drug category (i.e., drugs still under patent or those once covered by patents) have two components: a basic rebate and an additional rebate. For these single source and multiple source innovator drugs (i.e., brand-name drugs), Medicaid's basic rebate is the larger of (1) the greater of the drug's average manufacturer's price (AMP) or the best price for the same period, or (2) a flat percentage (23.1%) of the drug's quarterly AMP. Drug manufacturers also owe an additional rebate when they raise a drug's price faster than the inflation rate since the drug was first introduced to the market. The additional rebate is added to the basic rebate to get a brand drug's total rebate. Medicaid rebates for generic drugs have only a basic rebate component, without an adjustment when prices rise faster than inflation. For generic drugs, manufacturers' Medicaid rebates are 13% of each drug's AMP.

Manufacturers sometimes market their innovator single source products, or versions of these products, as over-the-counter products, before their patents expire. When AMPs for over-the-counter sales are combined with AMPs for single source product sales, drug manufacturers' Medicaid rebate obligations can be reduced because over-the-counter prices generally are lower than the innovator product AMPs, thus reducing the innovator product AMPs.

Prior to the ACA, modifications to existing drugs—new dosages or formulations—generally were considered new products for purposes of reporting AMPs to CMS. As a result, when drug makers introduced new formulations of existing products, they sometimes would have lower additional rebate obligations for these line-extension products. The ACA included a provision that required manufacturers to pay Medicaid rebates (both basic and additional) on line-extension products as if they were the original product.

[52] For more information on these and other Medicaid prescription drug issues, see CRS Report R43778, *Medicaid Prescription Drug Pricing and Policy*, by Cliff Binder.

Authorized generics are drugs that the original patent holder has licensed to a generic drug manufacturer to sell at a negotiated, reduced price that is higher than the price would be if the drug were subject to competition from other generic drug manufacturers. Including authorized generic sales with brand sales has the effect of lowering a product's AMP, thereby decreasing manufacturers' Medicaid rebate obligations for those products (both the basic and the additional rebate might be decreased).

Medicaid law requires the Secretary to establish federal upper limits when there are at least three generically and pharmacologically equivalent drugs manufactured. Medicaid drug federal upper limits help to ensure that federal payments do not exceed market rates. Medicaid drug federal upper limits are calculated based on the weighted average price of all drugs identified by each product billing code.

President's Proposal

The President's budget would introduce the following legislation to lower the cost of Medicaid outpatient drugs and strengthen the Medicaid drug rebate program:

- clarify that even when manufacturers convert innovator multiple source products into over-the-counter products, those drugs still are to be considered brand-name drugs for calculating Medicaid rebates;
- collect an additional inflation rebate for generic drugs when manufacturers increase prices faster than the inflation rate;
- clarify that certain vitamins and fluorides are included as Medicaid-covered outpatient drugs when prescribed for prenatal care;
- make a technical correction to the ACA alternative rebate for new drug formulations provision that amended federal Medicaid law to ensure that Medicaid rebates are applicable to line-extension drugs;
- limit to 12 quarters the time for manufacturers to dispute state utilization data, which would provide an incentive to manufacturers and states to resolve outstanding disputes;
- require manufacturers to exclude authorized generic drug sales from AMP calculations used as the basis to compute Medicaid rebate obligations for single source drugs;
- revise Medicaid federal upper limit calculations to include only generic drug prices; and
- exempt manufacturers' emergency drug supply program sales from the Medicaid rebate calculations and best price.

These proposals were modifications of provisions that were included in the President's FY2015 budget.

The Administration estimates the eight policies under this proposal would save $6.3 billion over the next 10 years.

Promote Program Integrity for Medicaid Drug Coverage

Current Law

Medicaid drug rebates paid by manufacturers to Medicaid are calculated based on each manufacturer's AMP for each drug. AMP is defined in law. Studies and legal settlements between drug manufacturers and state Medicaid programs have shown irregularities in how manufacturers interpreted CMS guidance on what sales transactions should be included in AMP.[53] States are permitted to exclude coverage for certain drugs, but they also may cover these drugs. Manufacturers sometimes include in their AMP calculations Medicaid-excluded drug transactions as well as other non-FDA approved products. By including these excluded and non-approved drug sales in their AMP calculation, manufacturers can reduce the amount of Medicaid rebates. CMS has the authority to survey drug manufacturers, and the HHS OIG has the authority to audit drug manufacturers. CMS and OIG monitor Medicaid prescription drug prices submitted by manufacturers and the rebates these companies pay to the Medicaid program, which are shared between states and the federal government. Even though drug manufacturers' methodologies and assumptions for reporting drug prices can affect rebates, CMS generally does not verify that manufacturers' documentation supports their prices, and it does not routinely check that their price determinations are consistent with Medicaid statute, regulations, or the rebate agreement.[54]

Under federal law and regulation, outpatient prescription drugs may be covered by Medicaid if the drugs were FDA approved.[55] Federal regulations limit Medicaid drug reimbursement for a drug prescribed off-label to those indications where a drug is listed in one or more of several named compendia, which are reference documents that list how most drugs may be used both on- and off-label (i.e., when drugs are prescribed for indications or dosage forms that were not FDA approved). Even though current law requires drug manufacturers to list their products with the FDA, not all drugs on the market are properly listed. Under federal law, individuals and entities that participate in a federal health program can be subject to fines, program exclusion, and/or criminal penalties for fraud, but these penalties are not specifically applicable to the Medicaid drug rebate program.

President's Proposal

The President's budget includes the following policies that would promote program integrity for Medicaid drug coverage:

- require manufacturers that improperly reported in their AMP calculations drugs not covered by Medicaid or not FDA approved to compensate states for any drug rebate underpayments;
- if cost effective, allow more regular audits and surveys of drug manufacturers to ensure compliance with the Medicaid drug rebate agreements;

[53] See Government Accountability Office (GAO), *Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States*, GAO-05-102, February 2005.

[54] Ibid.

[55] For more information on the Food and Drug Administration's (FDA's) drug approval process, see CRS Report R41983, *How FDA Approves Drugs and Regulates Their Safety and Effectiveness*, by Susan Thaul.

- require drug manufacturers to electronically list their products with the FDA in order to be covered and reimbursed by Medicaid, which would align Medicaid drug coverage requirements with Medicare's requirements; and
- increase penalties on drug manufacturers that knowingly report false information under Medicaid drug rebate agreements that are used to calculate Medicaid rebates.

This proposal was a modification of a proposal included in the President's FY2015 budget.

The Administration estimates the policies under this proposal would save $10 million over the next 10 years.

Increase Access to and Transparency of Medicaid Drug Pricing Data

Current Law

Section 6001 of the DRA amended the Social Security Act to require the Secretary to survey retail pharmacy prices and appropriated $5 million annually for five years to fund the survey and other reporting requirements. The retail price survey was to be a nationwide survey of average consumer prices of outpatient drugs, net of all discounts and rebates (price concessions). To obtain information on retail consumer prices and price concessions, CMS implemented a two-part survey. Part I of the survey collected consumer price information, and part II collected information on pharmacies' acquisition costs. Acquisition cost is used to help states set reasonable prescription drug payment rates. CMS retained a vendor to assist in the survey but suspended the consumer price survey in July 2013 due to budget limitations.

Even though the Social Security Act gives the Secretary authority to survey wholesalers to verify manufacturer prices when necessary, the statute does not provide the authority to collect wholesale prices on a regular basis, nor does the authority apply the data collection to all Medicaid-covered drugs. To determine if drug manufacturers are accurately reporting required pricing information on AMP, average sales price, and, where appropriate, best price, it would be necessary for CMS to collect wholesale acquisition cost data from drug wholesalers.

President's Proposal

The President's budget included the following policies to increase transparency and access to Medicaid drug pricing data:

- provide mandatory funding for five years ($6 million annually) to sustain the nationwide pharmacy survey that incorporates retail drug prices paid by cash, third-party insured, and Medicaid-insured consumers. The proposal also would fund the collection of drug invoice prices paid by retail community pharmacies; and
- authorize the Secretary to survey wholesale acquisition costs for all Medicaid-covered drugs on a regular basis, which would enable CMS to verify AMPs reported through drug wholesalers and to better set Medicaid drug federal upper limits.

This proposal was a modification of a proposal included in the President's FY2015 budget.

The Administration estimates the policies under this proposal would save $30 million over the next 10 years.

Estimated Cost/Savings for Medicaid Legislative Proposals

If these Medicaid proposals are implemented, the President's budget estimates that total net outlays for Medicaid would increase by $6.6 billion in FY2016 and by a cumulative $26.7 billion over the next 10 years. **Table 4** shows the estimated cost/savings for each legislative proposal in Medicaid.

Table 4. Estimated Cost/Savings for Medicaid Legislative Proposals Included in the President's FY2016 Budget Proposal

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Medicaid Benefits				
Expand State Flexibility to Provide Benchmark Benefit Packages	R	—	—	—
Require Coverage of Early and Periodic Screening, Diagnostic, and Treatment for Children in Inpatient Psychiatric Treatment Facilities	N	30	180	425
Provide Home- and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities	N	0	597	1,625
Require Full Coverage of Preventive Health and Tobacco-Cessation Services for Adults in Traditional Medicaid	R	95	431	754
Pilot Comprehensive Long-Term Care State Plan Option	N	0	2,345	4,085
Allow States to Develop Age-Specific Health Home Programs	N	200	570	1,010
Allow Full Medicaid Benefits to All Individuals in a Home- and Community-Based Services State Plan Option	N	1	15	38
Expand Eligibility Under the Community First Choice Option	N	238	1451	3,581
Expand Eligibility for the 1915(i) Home- and Community-Based Services State Plan Option	N	26	439	1,341
Create Pilot to Expand PACE Eligibility to Individuals Between the Ages of 21 and 55[a]	R	—	—	—
Medicaid Coverage				

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Extend the Transitional Medical Assistance Program Through CY2016	M	1,075	1,825	1,825
Permanently Extend "Express Lane" Eligibility Option for Children	R	20	215	680
Allow Pregnant Women Choice of Medicaid Eligibility Category	N	—	—	—
Create State Option to Provide 12-Month Continuous Medicaid Eligibility for Adults	N	600	10,200	27,700
Extend the Qualified Individual Program[a]	R	—	—	—
Medicaid Payments				
Rebase Future Medicaid Disproportionate Share Hospital Allotments	R	0	0	-3,290
Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates	R	-305	-1,780	-4,270
Extend the Medicaid Primary Care Payment Increase Through CY2016 and Include Additional Providers	M	5,010	6,290	6,290
Medicaid Prescription Drugs				
Lower Medicaid Drug Costs and Strengthen the Medicaid Drug Rebate Program	M	-276	-2,543	-6,325
Promote Program Integrity for Medicaid Drug Coverage	M	-1	-5	-10
Increase Access to and Transparency of Medicaid Drug Pricing Data	M	6	30	30
Other				
Ensure Retroactive Part D Coverage of Newly-Eligible Low-Income Beneficiaries[a]	R	—	—	—
Integrate Appeals Process for Medicare-Medicaid Enrollees[a]	R	—	—	—
Savings from Program Integrity[b]		-19	-305	-700
Interactions[c]		-84	-7,242	-8,055
Total Proposals Impacting Medicaid		**$6,617**	**$12,713**	**$26,734**

Source: Table created by CRS based on data from HHS, *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Totals may not add due to rounding.

PACE: Program of All-Inclusive Care for the Elderly.

a. These proposals impact both the Medicare and Medicaid programs. See the "Medicare Legislative Proposals" section for descriptions of these legislative proposals.

b. See "Program Integrity Legislative Proposals" for descriptions of the program integrity legislative proposals impacting Medicaid. Excludes savings not subject to pay-as-you-go (PAYGO) and excludes the proposal to Expand Funding and Authority for the Medicaid Integrity Program, which is described in the "Program Integrity Legislative Proposals" but accounted for in the tables in the "State Grants and Demonstrations Legislative Proposals."

c. These interactions are legislative proposals for other departments or agencies that are estimated to have a budgetary effect on Medicaid. The following is a list of the Medicaid Interactions in the President's FY2016 budget request: extending CHIP funding through FY2019, establishing hold-harmless for federal poverty guidelines, creating demonstration to address overprescription of psychotropic medications for foster care children, extending Special Immigrant Visa Program, extending Supplemental Security Income time limits for Qualified Refugees, modernizing child support, modifying length of exclusivity to facilitate faster development of generic biologics, and prohibiting brand and generic drug manufacturers from delaying the availability of new generics drugs and biologics.

Program Integrity Legislative Proposals

Medicare

Retain a Portion of Medicare Recovery Audit Recoveries to Implement Actions That Prevent Fraud and Abuse

Current Law

Under Section 306 of the MMA, Congress authorized a three-year demonstration to test the feasibility of using recovery audit contractors (RACs) that were paid solely on a contingency basis to identify Medicare fee-for-service overpayments. The RAC demonstration was successful and was converted to a permanent program by Section 302 of the Tax Relief and Healthcare Act of 2006 (P.L. 109-432). RACs are responsible for reducing Medicare's improper payment rates by identifying underpayments and overpayments made to providers and recovering overpayments. RACs are paid a percentage of the overpayments they recover from Medicare providers and suppliers. In FY2013, RAC contractors for Medicare Parts A and B identified approximately $2.3 billion in claim corrections, $2.2 billion of which were overpayments and $102 million of which were underpayments. Under current law, CMS may use RAC recoveries to administer the RAC program but not for other purposes, such as implementing new system edits and provider education and training.

President's Proposal

This proposal would amend the Social Security Act to authorize the Secretary to use RAC recoveries for other program integrity activities. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $2.8 billion over the next 10 years.

Allow Prior Authorization for Medicare Fee-for-Service Items

Current Law

Under current law, Medicare covers DME, including power wheelchairs and other power mobility devices, when it is determined to be medically necessary. There is a history of fraud and abuse associated with DME and power mobility devices, wherein beneficiaries receive power mobility devices that are not medically necessary or Medicare is charged for equipment that is never delivered. The Secretary has the authority to require prior authorization for DME items. CMS began a demonstration in 2012 that requires power mobility devices in seven states to receive Medicare prior authorization before beneficiaries receive equipment. The demonstration was extended to an additional 12 states in 2014.

Medicare also covers certain imaging services. Over the last decade, the growth of imaging services provided under the Medicare program has exceeded those of most other Part B services. A GAO study (GAO-12-966) found that "[f]rom 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services—magnetic resonance imaging (MRI) and computed tomography (CT) services—both increased, with the larger increase among self-referred services." These and other findings raise concerns about whether advanced imaging services are being used appropriately in the Medicare program.

President's Proposal

The President's budget proposal would extend the Secretary's authority to require prior authorization to all Medicare fee-for-service items. In addition, the proposal would require the Secretary to impose prior authorization requirements for power mobility and advanced imaging services. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $90 million over the next 10 years.

Allow Civil Monetary Penalties or Intermediate Sanctions for Providers and Suppliers Who Fail to Update Enrollment Records

Current Law

Participating Medicare providers and suppliers are required to submit updated enrollment information within specified time frames to comply with Medicare law. CMS uses provider and supplier enrollment records to monitor provider status. Current provider records help to ensure that providers that could pose a higher risk of fraudulent activity receive greater scrutiny when applying and afterward in submitting reimbursement claims.

President's Proposal

This provision in the President's FY2016 budget would authorize the Secretary to impose civil monetary penalties on providers and suppliers that fail to update enrollment records on a timely basis. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $29 million over the next 10 years.

Assess a Fee on Physicians and Practitioners Who Order Services or Supplies Without Proper Documentation

Current Law

Section 6406(b) of the ACA required certain Medicare providers and suppliers at increased fraud risk, including home health agencies (HHAs) and DME suppliers, to maintain and upon request provide documentation to support services ordered for Medicare beneficiaries. In addition, Section 6407(a)-(b) required providers and suppliers to ensure that Medicare beneficiaries for whom their services were ordered had a recent face-to-face encounter with a physician (or certain practitioners working with a physician) to determine the beneficiaries' eligibility for an initial episode of care. Physicians ordering services were required to document that those beneficiaries seen during the face-to-face encounter met Medicare's criteria for the ordered service. The face-to-face encounter was required to have occurred within 90 days prior to or within 30 days after the start of care.

President's Proposal

President's FY2016 budget would allow the Secretary to assess an administrative fee on providers for high-risk, high-cost claims, such as home health and DME, that were improperly documented. The Secretary would assess the administrative fee only when the ordering provider's documentation for the service (such as documentation for the face-to-face encounter) was insufficient to support the need for the service. There would be no administrative fee if the documentation was adequate to support the services ordered by the provider and the services were found to be reasonable and necessary. Under this proposal, the administrative fee for insufficient documentation for higher-risk services would be set at $50 for Part B supplies or services and $100 for Part A services. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary effect over the next 10 years.

Establish Registration Process for Clearinghouses and Billing Agents

Current Law

Many Medicare providers contract with third parties to prepare, edit, and/or submit claims on their behalves. These billing companies are referred to as *clearinghouses* and *billing agents*. Unlike the Medicare providers that contract with them, billing agents are not required to obtain provider identifiers or otherwise enroll as Medicare providers and suppliers. When billing agents and clearinghouses submit provider claims to Medicare, CMS receives information only on the provider, not on the entity actually submitting the reimbursement claim. CMS cannot identify or otherwise monitor billing agents. Billing agents and their employees have access to patient and provider information needed to access the Medicare system that could be misused without the provider's knowledge to submit false claims. CMS does not have authority to require billing agents and other billing companies to register or to certify that their employees have not been barred from participation in or otherwise sanctioned by Medicare. The ACA authorized the Secretary to require billing agents and related entities that submit claims on behalf of Medicaid providers to register with the Secretary and state Medicaid agency as determined by the Secretary.

President's Proposal

This proposal would expand the ACA's provider screening activities by authorizing the Secretary to establish a process for clearinghouses and billing agents that act on behalf of Medicare suppliers and agents to register with Medicare. This proposal would align Medicare's billing agent requirements with the requirements for billing agents serving Medicaid providers. In addition, this proposal would authorize the Secretary to charge billing companies an application fee to register as new Medicare suppliers. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary effect over the next 10 years.

Allow Collection of Application Fees from Individual Providers

Current Law

Section 6401(a) of the ACA authorized the Secretary to impose an application and revalidation fee on institutional providers that wanted to enroll or reenroll as Medicare providers. The Secretary was authorized to use the Medicare institutional application fee to offset the cost of program integrity activities, including provider enrollment and screening. The Medicare institutional provider application fee is adjusted annually based on changes to the consumer price index for all urban consumers. The CY2015 Medicare application fee was $553, but the Secretary was authorized to waive the fee when it might pose a hardship to the provider.

President's Proposal

This proposal would authorize the Secretary to require noninstitutional Medicare suppliers and providers to pay application fees when enrolling or revalidating as Medicare providers. The noninstitutional application fee would start at $50 and then be adjusted annually for inflation. The Secretary also would be authorized under this provision to grant hardship exemptions from the enrollment revalidation fee at the Secretary's discretion. The funds collected from the Medicare noninstitutional provider application/revalidation fee would be used to help support provider screening activities. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary effect over the next 10 years.

Increase the Amount of the Home Health Agency Surety Bond

Current Law

Medicare covers part-time or intermittent home health services under both Parts A and B.[56] Home health services include skilled nursing services, physical and occupational therapy, speech

[56] For more information on Medicare home health services, see CRS Report R42998, *Medicare Home Health Benefit Primer: Benefit Basics and Issues*, by Scott R. Talaga.

therapy, medical social services, and home health aide services. Home health service providers consistently have been associated with high improper payment rates and other vulnerabilities.[57] HHS has been unable to collect most improper payments from HHAs. BBA97 required the Secretary to impose surety bonds on Medicare HHAs. Regulations promulgated in 1998 set the surety bond amount at the greater of $50,000 or 15% of the annual amount paid in Medicare claims. Those regulations are pending. Congressional oversight agencies such as OIG and GAO recommended that CMS require surety bonds that would help to improve overpayment recoveries from HHAs.

President's Proposal

The proposal would increase the required surety bond amount for Medicare HHAs, making it no less than $50,000 and commensurate with the volume of payments made by Medicare to an HHA. This policy would align the HHA surety bond requirements with Medicare's requirements for DME suppliers and better ensure that potential overpayments made to new HHAs could be collected. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary effect over the next 10 years.

Medicaid

Expand Funding and Authority for the Medicaid Integrity Program

Current Law

Program integrity initiatives are designed to combat fraud, waste, and abuse. This includes processes directed at reducing improper payments, as well as activities intended to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse. Program integrity encompasses a broad range of activities intended to ensure proper payments are made. Among other changes, the DRA amended the Social Security Act to add Section 1936, which established the Medicaid Integrity Program (MIP). Section 1936 appropriated as much as $75 million annually in MIP funding to support and enhance state program integrity efforts by expanding and sustaining national activities such as provider audits, overpayment identification, payment integrity, and quality-of-care education. Section 1936, as originally enacted, restricted how MIP funding could be used and required that the Secretary employ 100 full-time equivalent staff. Moreover, Section 1936 restricted MIP funding to contractor payments and limited the Secretary's ability to use MIP funds for equipment, travel, benefits, training, and salaries.

President's Proposal

The President's budget would increase MIP funding by $0.6 billion over 10 years and increase the Secretary's flexibility to use MIP funding for a broader range of MIP activities. The additional investment would start with $25 million in FY2016 and gradually increase to an additional $0.1

[57] HHS, Office of Inspector General, *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments* (OEI-03-12-00070), September 2012.

billion for MIP activities in FY2025. Thereafter, the total MIP appropriation would be adjusted annually for inflation by the consumer price index. This new MIP funding would support the expansion of the Medicaid Financial Management program reviews of state financing practices; update the Medicaid claims and oversight systems to enhance auditing; and promote other efforts to assist states in fighting fraud, waste, and abuse. This proposal also would expand the MIP's authority to increase program flexibility in protecting state and federal resources. *This proposal was not included in the President's FY2015 budget.* (This proposal affects both the program integrity and the state grants and demonstrations portion of the CMS budget.)

The Administration estimates this proposal would cost $0.6 billion over the next 10 years.

Support Medicaid Fraud Control Units for the Territories

Current Law

Different federal Medicaid rules apply to the U.S. territories than to the states and the District of Columbia.[58] For example, federal funding for states is an open-ended entitlement, but Medicaid funding for the territories is a capped allotment. U.S. territories administer their Medicaid programs similarly to states, although Medicaid rules applicable to the territories differ from those applicable to states. Territories are not required to cover the same eligibility groups and they use different financial standards to determine eligibility. Territories generally have tailored their Medicaid programs to maximize federal funds to provide as many services as possible. In 2005, a GAO report reviewing the Medicaid eligibility and benefit coverage in the territories found that some of the territories did not meet the Medicaid eligibility requirements and that none of the territories covered all the Medicaid mandatory benefits.[59]

Medicaid Fraud Control Units (MFCUs) are separate state government entities certified to investigate and prosecute health care providers suspected of defrauding a state's Medicaid program. In addition, MFCUs have authority to review complaints about nursing home resident neglect or abuse and patient abuse complaints in other health care facilities receiving Medicaid payments. Subject to limitations, MFCUs are funded partially through a grant from the HHS OIG (75%) and partially with matching state funds (25%). Currently, no territories operate MFCUs.

President's Proposal

The President's budget would encourage territories to establish MFCUs by exempting federal support for MFCUs from the territories' Medicaid funding cap and by exempting territories from the statutory ceiling on quarterly federal payments for the units. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $0.01 billion over the next 10 years.

[58] The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

[59] Government Accountability Office, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, October 14, 2005.

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid

Current Law

Medicaid statute gives states broad authority to implement prescription drug monitoring activities, although not all states have adopted these activities. Several states have implemented voluntary or mandatory "lock-in" programs that require Medicaid beneficiaries who use prescription drugs at levels above certain medically necessary utilization guidelines to obtain services only from designated providers, such as one pharmacy or a specific primary care provider. States also have linked Medicaid data with statewide prescription drug monitoring programs to help identify controlled substance abuse. In addition to Medicaid authority to impose restrictions, some states have passed laws to increase penalties on individuals who participate in diverting Medicaid drugs from medically necessary uses to drug abuse or fraudulent activities.

President's Proposal

The President's budget would require states to monitor high-risk Medicaid drug billing to identify and remediate prescribing and utilization patterns that could indicate potential abuse or excessive prescription drug utilization. States could choose one or more drug classes subject to overuse or abuse, and states would be required to develop and review or update their high-utilization remediation plan. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $0.7 billion over the next 10 years.

Consolidate Redundant Error Rate Measurement Programs

Current Law

The Improper Payments Information Act of 2002 (IPIA; P.L. 107-300) required federal agencies to review annually the programs they oversee that may be susceptible to erroneous payments, in order to estimate improper payments and report the estimates to Congress before March 31 of the following year. In addition, if estimated improper payments exceeded $10 million per year, IPIA required federal agencies to identify ways to reduce erroneous payments. In response to IPIA, CMS implemented the Medicaid Payment Error Rate Measurement program, which estimates improper Medicaid and CHIP payments. In addition to Payment Error Rate Measurement, federal Medicaid law requires states to assess Medicaid eligibility quality control by calculating and reporting erroneous Medicaid payment and eligibility determination rates. States have discretion to develop and implement their own Medicaid eligibility quality-control methodologies. Under CMS Payment Error Rate Measurement regulations, states now have the option to use Payment Error Rate Measurement to fulfill the Medicaid eligibility quality-control requirement.

President's Proposal

The President's budget would authorize the Secretary to consolidate the Medicaid eligibility quality-control and Payment Error Rate Measurement programs. *This proposal was included in the President's FY2015 budget.*

The Administration estimates that this proposal would have no budgetary effect over the next 10 years.

Expand Medicaid Fraud Control Unit Review to Additional Care Settings

Current Law

MFCUs are separate state government entities certified to investigate and prosecute health care providers suspected of defrauding the state's Medicaid program. MFCUs also have authority to review complaints about nursing home resident neglect or abuse and patient abuse complaints in other health care facilities receiving Medicaid payments. MFCUs may review complaints alleging misappropriation of patient funds. MFCUs may not receive federal matching funds for patient abuse or neglect investigations that occur in noninstitutional settings, such as home- and community-based settings.

President's Proposal

The President's budget would allow MFCUs to receive federal matching funds for the investigation and prosecution of abuse and neglect in noninstitutional settings. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary effect over the next 10 years.

Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP

Current Law

Both Medicaid and CHIP are funded jointly by the federal government and states. The federal government's share of most Medicaid expenditures is called the federal medical assistance percentage, and federal CHIP matching funds are paid to states at an enhanced federal medical assistance percentage. The federal government provides broad guidelines to states regarding allowable funding sources for the state share (also referred to as the nonfederal share) of Medicaid and CHIP expenditures. However, to a large extent, states are free to determine how to fund their share of Medicaid expenditures. Federal regulations stipulate that the state share of Medicaid and CHIP cannot be funded with federal funds.

President's Proposal

The President's budget would codify the principle that states are prohibited from using federal funds to pay the state share of Medicaid or CHIP, unless specific exceptions were authorized in law. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Medicare and Medicaid

Permit Exclusion from Federal Health Care Programs If Affiliated with Sanctioned Entities

Current Law

The OIG has authority to exclude health care providers (individuals and entities) convicted of crimes from participation in federal health care programs.[60] The OIG's exclusion authority is mandatory in some circumstances (depending on the severity of the conviction) and permissive in others where OIG has discretion whether or not to exclude an individual from federal health care program participation.[61] The ACA extended the OIG's permissive exclusion authority to apply to individuals or entities that knowingly make false statements, omission, or misrepresentations of material facts in federal health care program enrollment applications, agreements, bids, or contracts to participate or enroll as a provider or supplier including explicit applicability to Medicare Advantage plans, prescription drug plans, and these organizations' providers and suppliers. Under current law, a loophole exists where entities and corporate officers, managing employees, and owners can evade federal health care program exclusions by resigning from a sanctioned entity. This loophole extends to entities and individuals with relationships to a sanctioned entity or individual.

President's Proposal

The President's budget would further expand OIG's authority to exclude individuals and entities from federal health programs if they were affiliated with sanctioned entities. The proposal would eliminate the loophole that allows the officers, managing employees, or owners of sanctioned entities to evade exclusion from federal health programs by resigning their positions or divesting their ownership interests. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would save $70 million over the next 10 years.

Establish Gifting Authority for the Healthcare Fraud Prevention Partnership

Current Law

The Healthcare Fraud Prevention Partnership is a voluntary public-private partnership between the federal government, state officials, law enforcement, private health insurance plans and their national associations, and healthcare antifraud associations. The Healthcare Fraud Prevention Partnership was established in September 2012 when the Secretary and Attorney General signed its charter. Its intent is to facilitate the exchange of information and data to detect and prevent health care fraud. Under current law, federal funding for the Healthcare Fraud Prevention

[60] For exclusion purposes, federal health care programs are defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or part, by the United States Government. (§1128B(f) of the Social Security Act).

[61] There are convictions that can result in mandatory exclusion and 16 offenses for which the Secretary or OIG may use permissive authority to exclude individuals or entities.

Partnership comes from the Health Care Fraud and Abuse Control (HCFAC) account, but there are limitations on how HCFAC account expenditures may be used and HCFAC may accept gifts made only for unspecified purposes.

President's Proposal

The President's budget would authorize the Secretary to accept gifts to the Medicare trust funds for particular activities funded through the HCFAC account, such as the Healthcare Fraud Prevention Partnership. This proposal would allow for gifts to be made to support the Healthcare Fraud Prevention Partnership directly, and it would allow both public and private partners to support the antifraud program. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers

Current Law

There are no specific penalties for selling, trading, bartering, or otherwise distributing beneficiary or identification numbers or billing privileges. Beneficiary identification numbers and provider or supplier billing privileges could be used to submit fraudulent claims to federal health care programs.

President's Proposal

The President's budget proposal would strengthen penalties for knowingly distributing Medicare, Medicaid, or CHIP beneficiaries' identification or billing privileges. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Estimated Cost/Savings for Program Integrity Legislative Proposals

If these program integrity proposals are implemented, the President's budget estimates that total spending for program integrity would increase by $0.1 billion in FY2016 and by a cumulative $2.4 billion over the next 10 years. **Table 5** shows the estimated cost/savings for each legislative proposal for program integrity.

Table 5. Estimated Cost/Savings for Program Integrity Legislative Proposals Included in the President's FY2016 Budget Proposal

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Medicare				
Retain a Portion of Medicare Recovery Audit Recoveries to Implement Actions That Prevent Fraud and Abuse	R	$141	$1,109	$2,758
Allow Prior Authorization for Medicare Fee-for-Service Items	R	—	-40	-90
Allow Civil Monetary Penalties or Intermediate Sanctions for Providers and Suppliers Who Fail to Update Enrollment Records	R	-1	-11	-29
Assess a Fee on Physicians and Practitioners Who Order Services or Supplies Without Proper Documentation	N	—	—	—
Establish Registration Process for Clearinghouses and Billing Agents	N	—	—	—
Allow Collection of Application Fees from Individual Providers	N	—	—	—
Increase the Amount of the Home Health Agency Surety Bond	N	—	—	—
Medicaid				
Expand Funding and Authority for the Medicaid Integrity Program	N	25	180	580
Support Medicaid Fraud Control Units for the Territories	R	1	5	10
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	R	-20	-310	-710
Consolidate Redundant Error Rate Measurement Programs	R	—	—	—
Expand Medicaid Fraud Control Unit Review to Additional Care Settings	R	—	—	—
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	R	—	—	—
Medicare and Medicaid				
Permit Exclusion from Federal Health Care Programs If Affiliated with Sanctioned Entities	R	—	-20	-70
Establish Gifting Authority for the Healthcare Fraud Prevention Partnership	N	—	—	—
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	R	—	—	—
Total Program Integrity Savings from Legislative Proposals[a]		**$146**	**$913**	**$2,439**

Source: Table created by CRS based on data from HHS, *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Totals may not add due to rounding.

a. Note that **Table 1** shows program integrity savings of $0.9 billion because that figure is the overall program integrity savings, which includes the impact of savings not subject to pay-as-you-go (PAYGO) in addition to the legislative proposals.

CHIP Legislative Proposals

Extend CHIP Funding Through FY2019

Current Law

Federal funding for CHIP is provided through FY2015 with appropriation amounts specified in statute. Those amounts represent the overall annual ceiling on federal CHIP spending to the states, the District of Columbia, and the territories. CHIP was established as part of BBA97. Since that time, other federal laws have extended federal funding. For instance, CHIPRA provided federal funding for FY2009 through FY2013, and the ACA provided federal funding for FY2014 and FY2015.

President's Proposal

The President's budget would extend federal CHIP funding through FY2019. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $33.0 billion over the next 10 years.

Extend Child Enrollment Contingency Fund

Current Law

State allotments are the federal funds allocated to each state for the federal share of its CHIP expenditures. State CHIP allotment funds are provided annually, and the funds are available to states for two years. If a state's CHIP allotment for the current year, in addition to any allotment funds carried over from the previous year, is insufficient to cover the projected CHIP expenditures for the current year, a few different shortfall funding sources are potentially available. These sources include Child Enrollment Contingency Funds, redistribution funds, and Medicaid funds. For FY2009 through FY2015, Child Enrollment Contingency Funds have been available to states with both a funding shortfall (i.e., current-year CHIP allotment plus any unused CHIP allotment funds from the previous year are insufficient to cover the federal share of the state's CHIP program) and CHIP enrollment for children exceeding a target level.

President's Proposal

The President's budget would extend the Child Enrollment Contingency Fund through FY2019. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $0.2 billion over the next 10 years.

Extend Performance Bonus Fund

Current Law

CHIPRA established performance bonus payments for states that increased their Medicaid (not CHIP) enrollment among low-income children above a defined baseline. From FY2009 through FY2013, performance bonus payments were available to states. To qualify for bonus payments, states had to have (1) implemented five out of eight specified enrollment and retention provisions and (2) achieved state-specific targets for increasing Medicaid enrollment among children. There were two tiers of bonus payments depending on how much a state's enrollment exceeded the baseline. From FY2009 through FY2013, CHIPRA performance bonus payments totaled $1.1 billion over the 5 years and went to 27 states. Some states received payments in more than one year. The performance bonus payments expired after FY2013.

President's Proposal

The President's budget would extend the performance bonus payments through FY2019. *This proposal was not included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $1.4 billion over the next 10 years.

Estimated Cost/Savings for CHIP Legislative Proposals

If these CHIP proposals are implemented, the President's budget estimates that total net outlays for CHIP would increase by $0.6 billion in FY2016 and by a cumulative $35.1 billion over the next 10 years. **Table 6** shows the estimated cost/savings for each legislative proposal in CHIP.

Table 6. Estimated Cost/Savings for CHIP Legislative Proposals Included in the President's FY2016 Budget Proposal

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Extend CHIP Funding Through FY2019	N	$500	$33,000	$33,000
Child Enrollment Contingency Fund	N	50	200	200
Extend Performance Bonus Fund	N	—	1,250	1,400
Permanently Extend "Express Lane" Eligibility for Children[a]	R	10	250	490
Total Changes in Outlays from Legislative Proposals		**$560**	**$34,700**	**$35,090**

Source: Table created by CRS based on data from HHS, *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Totals may not add due to rounding.

CHIP: State Children's Health Insurance Program.

a. This legislative proposal impacts both Medicaid and CHIP. See the "Medicaid Coverage" section for a description of this legislative proposal.

State Grants and Demonstrations Legislative Proposals

Create Demonstration to Address Overprescription of Psychotropic Medications for Children in Foster Care

Current Law

Nearly all children in foster care are eligible for Medicaid and generally are entitled to the same set of Medicaid benefits as other children enrolled in Medicaid, including coverage for psychotropic medications (i.e., prescribed drugs that affect the brain chemicals related to mood and behavior to treat a variety of mental health conditions). Certain factors, such as longer involvement with the child welfare agency, being of school age, and living in a group setting, forecast a greater chance that a child in foster care will take psychotropic medications.[62] Little research has been conducted to show that psychotropic medications are effective and safe for children with mental health disorders. Federal child welfare law (Title IV-B, Subpart 1 of the Social Security Act) requires states to provide HHS with information about protocols they have in place for the appropriate use and monitoring of psychotropic medications.

President's Proposal

The President's budget proposes a five-year joint initiative between CMS and HHS's Administration for Children and Families, which administers child welfare programs and activities. This proposal would provide performance-based incentive payments to states through Medicaid to reduce reliance on psychotropic medications for children in foster care by encouraging the use of evidence-based screening, assessment, and treatment of trauma and mental health disorders. This proposal is paired with another legislative proposal in the Administration for Children and Families to support state efforts to build provider and system capacity that would receive separate funding. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $0.5 billion over the next 10 years.

[62] Ramesh Raghavan et al., "Psychotropic Medication Use in a National Probability Sample of Children in the Child Welfare System," *Journal of Child and Adolescent Psychopharmacology*, vol. 15, no. 1, 2005, p. 97.

Extend and Improve the Money Follows the Person Demonstration

Current Law

Under the Money Follows the Person demonstration, HHS is authorized to award competitive grants to states to transition institutionalized Medicaid beneficiaries into community-based residential settings with the goal of increasing the use of Medicaid HCBS. Money Follows the Person was established under the DRA and was extended by Section 2403 of the ACA, which also appropriated an additional $2.25 billion through FY2016. For each eligible Medicaid beneficiary who is transitioned, the state Medicaid program receives an increased federal Medicaid matching rate for 12 months. Eligible beneficiaries must reside in an institution for at least 90 consecutive days and continue to require the level of care provided in an institution. Medicare-covered days for short-term rehabilitative services do not count toward the 90-day period.

President's Proposal

The President's budget proposes to extend the Money Follows the Person demonstration through FY2020 within the existing appropriation. The proposal would authorize funds to be used to prevent individuals from entering an institution rather than only transitioning individuals from an institutional setting to a community-based setting. It also would reduce the institutional requirement from 90 days to 60 days and allow Medicare-covered days to count toward this requirement. Finally, the proposal would allow individuals in certain mental health facilities to transition to community-based residential settings. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Estimated Cost/Savings for State Grants and Demonstrations Legislative Proposals

If these state grants and demonstrations proposals are implemented, the President's budget estimates that spending for state grants and demonstrations would increase by $0.6 billion over the next 10 years. **Table 7** shows the estimated cost/savings for each legislative proposal in state grants and demonstrations.

Table 7. Estimated Cost/Savings for State Grants and Demonstrations Legislative Proposals Included in the President's FY2016 Budget Proposal

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Create Demonstration to Address Overprescription of Psychotropic Medications for Children in Foster Care	R	—	$390	$500
Expand Funding and Authority for the Medicaid Integrity Program[a]	N	25	180	580
Extend and Improve the Money Follows the Person Demonstration	R	—	—	—
Total Changes in Outlays from Legislative Proposals		**$25**	**$570**	**$1,080**

Source: Table created by CRS based on data from HHS, *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Totals may not add due to rounding.

a. This legislative proposal impacts both the program integrity and the state grants and demonstrations sections of CMS. See the "Program Integrity Legislative Proposals" section for description of this legislative proposal.

Program Management Legislative Proposals

Provide Mandatory Administrative Resources for Implementation

Current Law

The program management portion of the CMS budget includes funding for the administration of Medicare, Medicaid, CHIP, and other CMS activities. The program management activities include both discretionary and mandatory appropriations. Under current law, the mandatory program management funding ($0.1 billion) was established by the following five laws: the ACA, ARRA, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275), PAMA, and the Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185).

President's Proposal

The President's budget would increase mandatory funding for program management by $0.4 billion for implementation of the mandatory health care proposals in the President's budget. CMS plans to use this funding to implement systems changes and process improvements needed to generate additional savings, improve efficiency and enhance program integrity in a timely manner. *This proposal was included in the President's FY2015 budget.*

In addition, the President's budget would increase mandatory funding for program management by $0.6 billion to implement the reform Medicare physician payments and accelerate physician participation in high-quality and efficient health care delivery systems (discussed in "Medicare Legislative Proposals." *This proposal was not included in the President's FY2015 budget.*

The Administration estimates these two proposals would cost $1.0 billion over the next 10 years.

Invest in CMS Quality Measurement

Current Law

Under current law, two provisions authorize specified quality and performance measurement duties for a contracted consensus-based entity. Section 183 of MIPPA (Section 1890 of the Social Security Act) requires the Secretary to have a contract with a consensus-based entity (e.g., the National Quality Forum) to carry out specified performance-improvement and quality-measurement duties. These duties include, among others, priority setting, measure endorsement, measure maintenance, convening multi-stakeholder groups to provide input on the selection of quality measures and national priorities, and annual reporting to Congress. Section 3014 of the ACA added new duties for the consensus-based entity and required the Secretary to establish a pre-rulemaking process to select quality measures for use in federal health programs. This process involves duties shared between the consensus-based entity and the Secretary and includes gathering multi-stakeholder input; making measures under consideration available to the public, transmitting the input of multi-stakeholder groups to the Secretary, and publishing the rationale for the use of any quality measure in the *Federal Register*. Under current law, funding for these sections will expire on March 31, 2015.

President's Proposal

The President's budget would extend funding for the consensus-based entity to carry out the duties established under both Section 183 of MIPPA (Section 1890 of the Social Security Act) and Section 3014 of the ACA (Section 1890A of the Social Security Act). It would provide $30 million for each fiscal year from FY2016 through FY2018, with funds available until expended. The proposal does not specify the allocation of funding between the duties in the two sections. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would cost $90 million over the next 10 years.

Allow CMS to Reinvest Civil Monetary Penalties Recovered from Home Health Agencies

Current Law

Section 1891 of the Social Security Act requires Medicare HHAs as a condition of participation to comply with certain requirements, such as quality of care and safety standards. To verify an HHA's compliance with Medicare's conditions of participation, CMS contracts with each state survey agency to conduct a recertification survey every three years. HHAs that are out of compliance can be cited for deficiencies and face intermediate sanctions, such as directed plans of correction and temporary management changes. Beginning July 1, 2014, intermediate sanctions

for noncompliant HHAs included suspension of Medicare payments for new patient admissions and civil monetary penalties. Unless otherwise specified, Medicare law requires that civil monetary penalties levied and collected are returned to the Medicare trust funds. However, Section 6111 of the ACA permitted the Secretary to retain a portion of civil monetary penalties levied against noncompliant SNFs to support initiatives that improve the quality of SNF care.

President's Proposal

The President's budget would allow civil monetary penalties collected from HHAs to be retained and invested for activities to improve the quality of care of patients receiving home health services. *This proposal was included in the President's FY2015 budget.*

The Administration estimates these two proposals would cost $10 million over the next 10 years.

Allow CMS to Assess a Fee on Medicare Providers for Payments Subject to the Federal Levy Program

Current Law

Under the Federal Payment Levy Program, the Internal Revenue Service and the Department of the Treasury collect overdue taxes and non-tax debts through a continuous levy on certain federal payments disbursed by the Financial Management Service, including Medicare fee-for-service payments. CMS may reduce federal payments subject to the levy by 15%, or by the exact amount of the tax owed if it is less than 15% of the payment. CMS also may reduce federal payments subject to the non-tax levy by 100%, or by the exact amount of the non-tax debt owed if it is less than 100% of the payment.

President's Proposal

The President's budget would authorize CMS to assess a fee to offset the administrative costs of the Federal Payment Levy Program. The Department of the Treasury would continue to receive the full amount of the levy, and Medicare providers would be required to pay CMS fees to cover administrative costs for operating the Federal Payment Levy Program, which are estimated to be $2 million in FY2016. *This proposal was included in the President's FY2015 budget.*

The Administration estimates this proposal would have no budgetary impact over the next 10 years.

Estimated Cost/Savings for Program Management Legislative Proposals

If these program management proposals are implemented, the President's budget estimates that spending for program management would increase by $0.1 billion in FY2016 and by a cumulative $1.1 billion over the next 10 years. **Table 8** shows the estimated cost/savings for each legislative proposal in program management.

Table 8. Estimated Cost/Savings for Program Management Legislative Proposals Included in the President's FY2016 Budget Proposal

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2015 Budget	Administration's Cost/Savings Estimates		
		FY2016	FY2016-FY2020	FY2016-FY2025
Provide Mandatory Administrative Resources for Implementation	N	$85	$970	$1,000
Invest in CMS Quality Measurement	R	30	90	90
Allow CMS to Reinvest Civil Monetary Penalties Recovered from Home Health Agencies	R	1	5	10
Allow CMS to Assess a Fee on Medicare Providers for Payments Subject to the Federal Levy Program	R	—	—	—
Total Changes in Outlays from Legislative Proposals		**$116**	**$1,065**	**$1,100**

Source: Table created by CRS based on data from HHS, *Fiscal Year 2016 Budget in Brief: Strengthening Health and Opportunity for All Americans*, February 2015.

Notes: Totals may not add due to rounding.

CMS: Centers for Medicare & Medicaid Services.

Appendix. List of Abbreviations

ACA: The Patient Protection and Affordable Care Act (P.L. 111-148, as amended)

ACO: Accountable Care Organizations

ALS: Amyotrophic Lateral Sclerosis

AMP: Average Manufacturers' Price

ARRA: The American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

ASP: Average Sales Price

BBA97: Balanced Budget Act of 1997 (P.L. 105-33)

CAH: Critical Access Hospital

CHIP: State Children's Health Insurance Program

CHIPRA: Children's Health Insurance Program Reauthorization Act (P.L. 111-3)

CMS: Centers for Medicare & Medicaid Services

CT: Computed Tomography

DME: Durable Medical Equipment

DRA: Deficit Reduction Act of 2005 (P.L. 109-171)

DSH: Disproportionate Share Hospital

EPSDT: Early and Periodic Screening, Diagnostic and Treatment

ESRD: End-Stage Renal Disease

FDA: Food and Drug Administration

FPL: Federal Poverty Level

GAO: Government Accountability Office

GDP: Gross Domestic Product

HCBS: Home- and Community-Based Services

HCFAC: Health Care Fraud and Abuse Control

HHA: Home Health Agency

HHS: U.S. Department of Health & Human Services

IPAB: Independent Payment Advisory Board

IPIA: Improper Payments Information Act of 2002 (P.L. 107-300)

IRF: Inpatient Rehabilitation Facility

LIS: Low-Income Subsidy

LTCH: Long-Term Care Hospital

MA: Medicare Advantage

MA-PD: Medicare Advantage Plans with a Prescription Drug Component

MedPAC: Medicare Payment Advisory Commission

MFCU: Medicaid Fraud Control Unit

MIP: Medicaid Integrity Program

MIPPA: Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)

MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)

MRI: Magnetic Resonance Imaging

OIG: Department of Health & Human Services Office of Inspector General

PACE: Program of All-Inclusive Care for the Elderly

PAMA: Protecting Access to Medicare Act of 2014 (P.L. 113-93)

PAYGO: Pay-As-You-Go

PDP: Prescription Drug Plans

PPS: Prospective Payment System

QI: Qualified Individuals

RAC: Recovery Audit Contractors

SGR: Sustainable Growth Rate

SNF: Skilled Nursing Facility

SSI: Supplemental Security Income

TMA: Transitional Medical Assistance

Author Contact Information

Alison Mitchell, Coordinator
Analyst in Health Care Financing
amitchell@crs.loc.gov, 7-0152

Kirstin B. Blom, Coordinator
Analyst in Health Care Financing
kblom@crs.loc.gov, 7-2397

Patricia A. Davis, Coordinator
Specialist in Health Care Financing
pdavis@crs.loc.gov, 7-7362

Evelyne P. Baumrucker
Analyst in Health Care Financing
ebaumrucker@crs.loc.gov, 7-8913

Cliff Binder
Analyst in Health Care Financing
cbinder@crs.loc.gov, 7-7965

Kirsten J. Colello
Specialist in Health and Aging Policy
kcolello@crs.loc.gov, 7-7839

Jim Hahn
Specialist in Health Care Financing
jhahn@crs.loc.gov, 7-4914

Elicia J. Herz
Specialist in Health Care Financing
eherz@crs.loc.gov, 7-1377

Suzanne M. Kirchhoff
Analyst in Health Care Financing
skirchhoff@crs.loc.gov, 7-0658

Paulette C. Morgan
Specialist in Health Care Financing
pcmorgan@crs.loc.gov, 7-7317

Carol Rapaport
Analyst in Health Care Financing
crapaport@crs.loc.gov, 7-7329

Amanda K. Sarata
Specialist in Health Policy
asarata@crs.loc.gov, 7-7641

Scott R. Talaga
Analyst in Health Care Financing
stalaga@crs.loc.gov, 7-5956

Sibyl Tilson
Specialist in Health Care Financing
stilson@crs.loc.gov, 7-7368

Jennifer A. Staman
Legislative Attorney
jstaman@crs.loc.gov, 7-2610

Acknowledgments

Research assistant Austin Frerick assisted with many aspects of this report, including preparing the report's tables, fact checking, and reviewing for consistency.