Issue Brief

FEDERAL ISSUE BRIEF • February 11, 2016

President's FY 2017 Budget Released: Would Reduce Medicare Payments by $419.4 Billion Over 10 Years

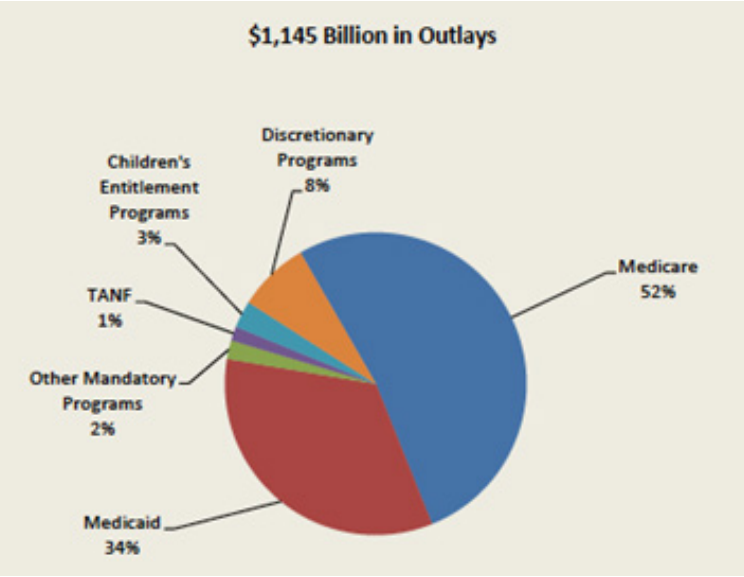
The White House has released the President Obama's fiscal year 2017 budget, and has forwarded it to the Congress where Republican leadership has already announced that it will not allow the Director of the Office of Management and Budget to testify on the document. This suggests that another presidential budget is "dead on arrival."

The U.S. Department of Health & Human Services budget detail includes 177 pages. A copy is available at: http://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf.

The FY 2017 HHS budget totals $1,145 billion in outlays.

The budget estimate for the Centers for Medicare & Medicaid Services is $970.8 billion in mandatory and discretionary outlays, a net increase of $74 billion above the FY 2016 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program, private health insurance programs and oversight, program integrity efforts, and operating costs.

The graphical representation of the presidents FY 2017 budget for HHS follows.



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MISSOURI HOSPITAL ASSOCIATION

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COMMENT

While the HHS budget addresses all aspects of the department, the material below focuses on CMS. Much of the budget details are not new. We have seen them before. But, as we always note, one never knows when Congress may act on such proposals. Many of the items would adversely impact providers. Of course, this being an election year the likelihood is that this budget is going nowhere.

MAJOR MEDICARE 2017 LEGISLATIVE PROPOSALS

Below are major Medicare components in the budget. A table is at the end of the discussion reflecting all Medicare legislative proposals.

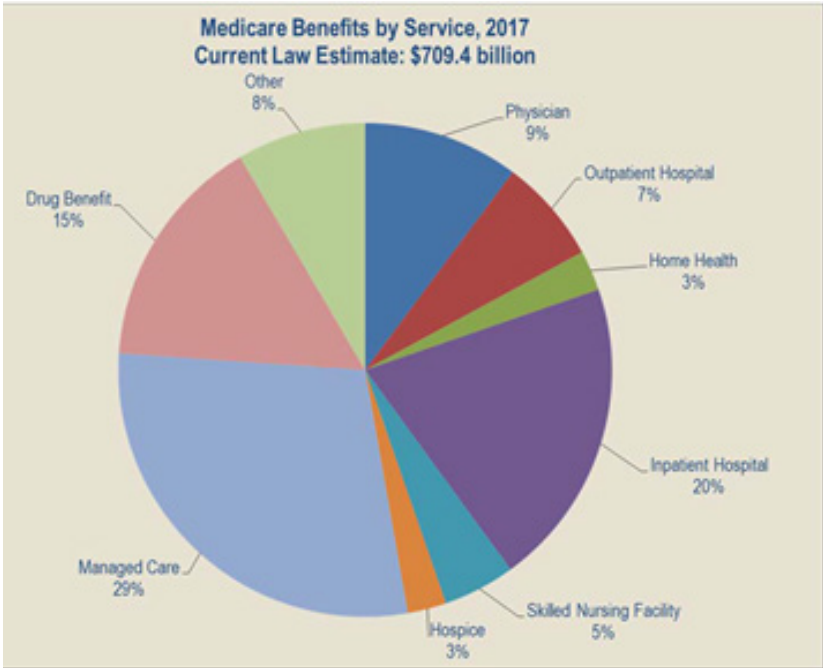
The budget includes net projected Medicare savings of $419.4 billion throughout 10 years.

For FY 2017, the Office of the Actuary has estimated that gross current law spending on Medicare benefits will total $709.4 billion. Medicare will provide health insurance to 58 million individuals who are age 65 or older, disabled, or have end-stage renal disease.

- Part A ($202.1 billion gross fee-for-service spending in 2017)
- Part B ($192.9 billion gross fee-for-service spending in 2017)
- Part C ($204.7 billion gross spending in 2017)
- Part D ($109.7 billion gross spending in 2017)

REFORM MEDICARE ADVANTAGE PAYMENTS TO IMPROVE THE EFFICIENCY AND SUSTAINABILITY OF THE PROGRAM

This proposal "incentivizes Medicare Advantage plans to submit cost-effective bids while preserving beneficiary rebates and standardizing quality bonus payments across counties. The proposal establishes competitive bidding in Medicare Advantage by calculating an adjusted benchmark, against which plans are paid, as the lesser of the current law fee-for-service benchmark or the average Medicare Advantage plan bid plus a five percent 'buffer' to protect beneficiary rebates. This competitively bid benchmark would – for the first time – allow CMS to use plan bids to



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set the benchmark and reward plans for lowering their bids by allowing them to retain 100 percent of the difference between their bid and the benchmark as the rebate. Additionally, the proposal would standardize quality bonus payments across counties by removing the doubling of the quality bonus payment which is only available in certain areas and lifting the cap on benchmarks for plans that are entitled to receive a quality bonus payment. This proposal prepares for the future of Medicare by Centers for Medicare & Medicaid Services reforming Medicare Advantage payments to improve efficiency and sustainability of the program for all Medicare beneficiaries. [**$77.2 billion in savings** over 10 years]"

IMPLEMENT BUNDLED PAYMENT FOR POST-ACUTE CARE

Beginning in 2021, this proposal implements bundled payment for post-acute care providers, including long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health providers.

"Payments will be bundled for at least half of the total payments for post-acute care providers. Rates based on patient characteristics and other factors will be set so as to produce a permanent and total cumulative adjustment of 2.85 percent by 2023. Beneficiary coinsurance will equal that under current law (e.g., to the extent the beneficiary uses skilled nursing facilities, the beneficiaries would be responsible for the current law coinsurance rate). [**$9.9 billion in savings** over 10 years]"

EXPAND BASIS FOR BENEFICIARY ASSIGNMENT FOR ACCOUNTABLE CARE ORGANIZATIONS TO INCLUDE NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CLINICAL NURSE SPECIALISTS

This proposal "allows the Secretary to base beneficiary assignment in the Medicare Shared Savings Program on a broader set of primary care providers. Under the proposal, beneficiaries will be assigned to an ACO on the basis of primary care services delivered by nurse practitioners, physician assistants, and clinical nurse specialists. The statute requires that assignment of beneficiaries to an ACO be based on their utilization of primary care services provided by physicians. Expanding the assignment of beneficiaries to nurse practitioners, physician assistants, and clinical nurse specialists, in addition to physicians, could broaden the scope of ACOs to better reflect the types of professionals that deliver primary care services to fee-for-service beneficiaries.

Some Medicare beneficiaries, especially those in rural or underserved areas, receive most or all of their primary care from non-physician practitioners. This proposal results in a greater number of Medicare fee-for-service beneficiaries who rely on these practitioners for their care being assigned to ACOs. [**$150 million in savings** over 10 years]

ELIMINATE THE 190-DAY LIFETIME LIMIT ON INPATIENT PSYCHIATRIC FACILITY SERVICES

"The 190-day lifetime limit on inpatient services delivered in specialized psychiatric hospitals is one of the last obstacles to behavioral health parity in the Medicare benefit. Beginning in FY 2017, this proposal would eliminate the 190-day limit and more closely align the Medicare mental health care benefit with the current inpatient physical health care benefit. Many beneficiaries who utilize psychiatric services are eligible for Medicare due to a disability, which means they are often younger beneficiaries who can easily reach the 190-day limit over their lifetimes. This

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proposal will expand the psychiatric benefit and bring parity to the sites of service, while also containing the additional costs of removing the 190-day limit. [**$2.4 billion in Medicare costs** over 10 years]"

ADJUST PAYMENT UPDATES FOR CERTAIN POST-ACUTE CARE PROVIDERS

This proposal "reduces marketbasket updates for inpatient rehabilitation facilities, long-term care hospitals and home health agencies by 1.1 percentage points in FY 2017 and each year FY 2019 through FY 2026. For 2018, the statute requires an update of 1 percent for these post-acute care providers. Payment updates for these providers would not drop below zero as a result of this proposal. This proposal will reduce marketbasket updates for skilled nursing facilities under an accelerated schedule, beginning with a -2.5 percent update in FY 2017; -2 percent in FY 2019; -1 percent in each year FY 2020-2023; and tapering down to a -0.97 percent update in FY 2024. Payment updates may drop below zero as a result of this proposal for skilled nursing facilities. [**$86.6 billion in savings** over 10 years]"

REDUCE MEDICARE COVERAGE OF BAD DEBTS

"For most institutional provider types, Medicare currently reimburses 65 percent of bad debts resulting from beneficiaries' nonpayment of deductibles and coinsurance after providers have made reasonable efforts to collect the unpaid amounts. Starting in 2017, this proposal would reduce bad debt payments to 25 percent over three years for all providers who receive bad debt payments. This proposal will more closely align Medicare policy with private payers, who do not typically reimburse for bad debt. [**$32.9 billion in savings** over 10 years]"

ENCOURAGE WORKFORCE DEVELOPMENT THROUGH TARGETED AND MORE ACCURATE INDIRECT MEDICAL EDUCATION PAYMENT

"The Medicare Payment Advisory Commission has found that existing Medicare add-on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur. This proposal will partially correct this imbalance by reducing these payments by 10 percent, beginning in 2017. In addition, the Secretary will be granted the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage resident training in areas of emerging need, such as primary care and medication-assisted treatment of substance use disorders, and emphasize skills that promote high-quality, high-value health care. [**$17.8 billion in savings** over 10 years]"

REFORM MEDICARE HOSPICE PAYMENTS

"CMS has taken steps to improve the accuracy of hospice benefit payments, but there are additional opportunities for improvement. This proposal reduces marketbasket updates for hospice providers by 1.7 percent in 2018, 2019, and 2020 as a first step toward aligning payment with costs of care. Payment updates for providers would not drop below zero as a result of this proposal. This proposal also permits the Secretary to implement a hospice-specific marketbasket by 2021. Currently, the hospice marketbasket is based on the hospital marketbasket, despite differences in the type of service provided (palliative vs. curative), the care setting (at home vs. inpatient), and the labor force utilized.

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Finally, this proposal permits the Secretary to make further budget neutral reforms to the hospice payment system. [**$9.3 billion in savings** over 10 years]"

EXCLUDE CERTAIN SERVICES FROM THE IN-OFFICE ANCILLARY SERVICES EXCEPTION

"There is evidence that suggests that this exception may have resulted in overutilization and the Centers for Medicare & Medicaid Services rapid growth of certain services. Effective calendar year 2018, this proposal seeks to encourage more appropriate use of ancillary services by amending the in-office ancillary services exception to prohibit certain referrals for radiation therapy, therapy services, advanced imaging and anatomic pathology services except in cases where a practice is clinically integrated and required to demonstrate cost containment, as defined by the Secretary. [**$5.0 billion in savings** over 10 years]"

PROVIDE AUTHORITY TO EXPAND COMPETITIVE BIDDING FOR CERTAIN DURABLE MEDICAL EQUIPMENT

"Since implementation, the Competitive Bidding Program for durable medical equipment, prosthetics, and supplies has saved the Medicare program and beneficiaries billions of dollars by aligning payment amounts with market-based prices. Currently this program is restricted to certain categories of equipment, supplies and services. This proposal expands the competitive bidding program to additional categories, including: inhalation drugs, all prosthetics and orthotics, and ostomy, tracheostomy, and urological supplies. [**$3.8 billion in savings** over 10 years]"

ENCOURAGE APPROPRIATE USE OF INPATIENT REHABILITATION FACILITIES

This proposal adjusts the standard for classifying a facility as an Inpatient Rehabilitation Facility. Under current law, at least 60 percent of patient cases admitted to an Inpatient Rehabilitation Facility must meet one or more of 13 designated severity conditions. This standard was changed to 60 percent from 75 percent in the Medicare, Medicaid, and SCHIP Extension Act of 2007. Beginning in 2017, this proposal reinstitutes the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. [**$2.2 billion in savings** over 10 years]

REDUCE CRITICAL ACCESS HOSPITAL REIMBURSEMENTS FROM 101 PERCENT OF REASONABLE COSTS TO 100 PERCENT OF REASONABLE COSTS

"Critical access hospitals generally are small, rural hospitals that provide their communities with access to basic emergency and inpatient care. Critical access hospitals receive enhanced cost-based Medicare payments (rather than the fixed-fee payments most hospitals receive). Medicare currently pays critical access hospitals 101 percent of reasonable costs. This proposal reduces this rate to 100 percent beginning in 2017. [**$1.7 billion in savings** over 10 years]"

PROHIBIT CAH DESIGNATION FOR FACILITIES THAT ARE LESS THAN 10 MILES FROM THE NEAREST HOSPITAL

"Beginning in 2017, this proposal prevents facilities that are within 10 miles of another hospital from maintaining designation as a critical access hospital and receiving the enhanced rate. These facilities will instead be paid under the applicable prospective payment system. [**$880 million in savings** over 10 years]"

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ALIGN MEDICARE DRUG PAYMENT POLICIES WITH MEDICAID POLICIES FOR LOW-INCOME BENEFICIARIES

"Currently, drug manufacturers are required to pay specified rebates for drugs dispensed to Medicaid beneficiaries. In contrast, Medicare Part D plan sponsors negotiate with manufacturers to obtain plan-specific rebates at unspecified levels. Analysis has found substantial differences in rebate amounts and prices paid for brand name drugs under the two programs, with Medicare receiving significantly lower rebates and paying higher prices than Medicaid. Prior to the establishment of Medicare Part D, manufacturers paid Medicaid rebates for drugs provided to the dual eligible population. This proposal allows Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Part D low-income subsidy, beginning in 2018.

The proposal requires manufacturers to pay the difference between rebate levels they already provide Part D plans and the Medicaid rebate levels. Manufacturers also will be required to provide an additional rebate for brand name and generic drugs when their prices rise faster than inflation. [**$121.3 billion in savings** over 10 years]"

CENTERS FOR MEDICARE & MEDICAID SERVICES INCREASE INCOME RELATED PREMIUMS UNDER MEDICARE PARTS B AND D

"Under Medicare Parts B and D, certain beneficiaries pay higher premiums based on their higher levels of income. Beginning in 2020, this proposal restructures income-related premiums under Medicare Parts B and D by increasing the applicable percent for calculating the lowest income-related premiums by 5 percentage points, from 35 percent to 40 percent of program costs, and creating new tiers at 52.5 percent, 65 percent, 80 percent and 90 percent. While last year's proposal had a fourth tier at 77.5 percent, this proposal keeps the tier for those making $160,000 to $196,000 at 80 percent, consistent with the new tier created by the Medicare Access and CHIP Reauthorization Act of 2015. The proposal also maintains the current income thresholds associated with these premiums until 25 percent of beneficiaries under Parts B and D are subject to these premiums. This proposal will help improve the financial stability of the Medicare program by reducing the federal subsidy of Medicare costs for those who need the subsidy the least. [**$41.2 billion in savings** over 10 years]"

INTRODUCE HOME HEALTH COPAYMENTS FOR NEW BENEFICIARIES

This proposal creates a co-payment for new beneficiaries of $100 per home health episode, starting in 2020. Consistent with MedPAC recommendations, this co-payment will apply only for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay. Home health services represent one of the few areas in Medicare that do not currently include some beneficiary cost-sharing. This proposal aims to encourage appropriate use of home health services while protecting beneficiary access. [**$1.3 billion in savings** over 10 years]

continued

FY 2017 MEDICARE LEGISLATIVE PROPOSALS

(Negative numbers reflect savings and positive numbers reflect costs)

Dollars in Millions	2017	2017-2021	2017-2026
Support Delivery System Reform			
Payment Incentives			
Reform Medicare Advantage Payments to Improve the Efficiency and Sustainability of the Program	—	-19,910	-77,240
Implement Bundled Payment for Post-Acute Care	—	-470	-9,850
Expand Basis for Beneficiary Assignment for Accountable Care Organizations to include Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists	—		-150
Allow CMS to Assign Beneficiaries to Federally Qualified Health Centers and Rural Health Clinics Participating in the Medicare Shared Savings Program	—	-20	-80
Allow Accountable Care Organizations to Pay Beneficiaries for Primary Care Visits up to the Applicable Medicare Cost-Sharing Amount	—	-40	-70
Establish a Bonus Payment for Hospitals Cooperating with Certain Alternative Payment Models	—	—	—
Establish a Hospital-Wide Readmissions Reduction Measure	—	—	—
Establish Quality Bonus Payments for High-Performing Part D Plans	—	—	—
Extend Accountability for Hospital-Acquired Conditions	—	—	—
Implement Value-Based Purchasing for Additional Providers	—	—	—
Care Delivery			
Expand the Ability of Medicare Advantage Organizations to Pay for Services Delivered via Telehealth	—	-60	-160
Allow the Secretary to Introduce Primary Care Payments under the Physician Fee Schedule in a Budget Neutral Manner	—	—	—
Information			
Add Certain Behavioral Health Providers to the Electronic Health Record Incentive			
Programs (non-add)	—	4,450	5,200
Medicare Impact	—	650	760
Medicaid Impact (non-add)	—	3,800	4,440
Increase Value in Medicare Provider Payments			
Eliminate the 190-day Lifetime Limit on Inpatient Psychiatric Facility Services	160	1,020	2,370
Update Medicare Disproportionate Share Formula for Hospitals in Puerto Rico	—	20	70
Adjust Payment Updates for Certain Post-Acute Care Providers	-1,600	-19,160	-86,580
Strengthen the Independent Payment Advisory Board to Reduce Long-Term Drivers of Medicare Cost Growth	—	-1,067	-36,394
Reduce Medicare Coverage of Bad Debts	-410	-11,320	-32,920

continued

Dollars in Millions	2017	2017-2021	2017-2026
Encourage Workforce Development Through Targeted and More Accurate Indirect Medical Education Payments	-1,170	-7,350	-17,800
Reform Medicare Hospice Payments	—	-2,590	-9,250
Exclude Certain Services from the In-Office Ancillary Services Exception	—	-1,750	-4,980
Provide Authority to Expand Competitive Bidding for Certain Durable Medical Equipment	—	-1,070	-3,750
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	-160	-960	-2,150
Increase Value in Medicare Provider Payments (Continued)			
Reduce Critical Access Hospital Reimbursements from 101 Percent of Reasonable Costs to 100 Percent of Reasonable Costs	-110	-690	-1,670
Prohibit Critical Access Hospital Designation for Facilities that are Less than 10 Miles from the Nearest Hospital	-60	-360	-880
Allow the Secretary to Determine Hospital Acquired Condition Program Penalty Amounts and Distribution	—	—	—
Clarify the Medicare Fraction in the Medicare Disproportionate Share Hospital Statute	—	—	—
Modernize Funding for End Stage Renal Disease Networks	—	—	—
Recoup Initial Clinical Laboratory Fee Schedule Payments for Advanced Diagnostic Laboratory Tests in Excess of 100 Percent of the Final Payment Amount	—	—	—
Repeal the Rental Cap for Oxygen Equipment	—	—	—
Address the Rising Cost of Pharmaceuticals			
Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries	—	-29,510	-121,250
Accelerate Manufacturer Discounts for Brand Drugs to Provide Relief to Medicare Beneficiaries in the Coverage Gap	—	-3,260	-10,210
Modify Reimbursement of Part B Drugs	—	-2,600	-7,750
Require Mandatory Reporting of Other Prescription Drug Coverage	-10	-170	-480
Allow the Secretary to Negotiate Prices for Biologics and High Cost Prescription Drugs	—	—	—
Change the Part D Coverage Gap Discount Program Agreements from Annually to Quarterly	—	—	—
Establish Authority for a Program to Prevent Prescription Drug Abuse in Medicare Part D	—	—	—
Increase Part D Plan Sponsors' Risk for Catastrophic Drugs	—	—	—
Require Evidence Development for Coverage of High Cost Drugs	—	—	—
Increase the Availability of Generic Drugs and Biologics			
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics (Medicare impact)	-800	-4,910	-12,250
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicare impact)	—	-1,580	-6,890
Establish Transparency and Reporting Requirements in Pharmaceutical Drug Pricing	—	—	—

continued

Dollars in Millions	2017	2017-2021	2017-2026
Medicare Structural Reforms			
Eliminate Beneficiary Coinsurance for Screening Colonoscopies with Polyp Removal	160	950	2,430
Increase Income Related Premiums under Medicare Parts B and D	—	-5,260	-41,230
Encourage the Use of Generic Drugs by Low-Income Beneficiaries	—	-3,330	-9,630
Modify the Part B Deductible for New Beneficiaries	—	-140	-4,230
Introduce Home Health Copayments for New Beneficiaries	—	-100	-1,300
Reforming the Medicare Appeals Process			
Provide Office of Medicare Hearings and Appeals and Department Appeals Board Authority to Use Recovery Audit Contractor Collections	127	635	1,270
Establish Magistrate Adjudication for Claims with Amount in Controversy Below			
New Administrative Law Judge Amount in Controversy Threshold	—	—	—
Expedite Procedures for Claims with No Material Fact in Dispute	—	—	—
Increase Minimum Amount in Controversy for Administrative Law Judge			
Adjudication of Claims to Equal Amount Required for Judicial Review	—	—	—
Remand Appeals to the Redetermination Level with the Introduction of New			
Evidence	—	—	—
Sample and Consolidate Similar Claims for Administrative Efficiency	—	—	—
Other Proposals			
Allow Beneficiaries to Pay a Sum Certain to Medicare for Future Medical Items and Services	—	-65	-65
Clarify Calculation of the Late Enrollment Penalty for Medicare Part B Premiums	—	—	—
Reduce Fraud, Waste, and Abuse in Medicare /1	111	612	1,443
Medicare-Medicaid Enrollee Proposals (Medicare Impact) /2	—	20	100
Interactions /3	33	15,660	71,328
Total/4	**3,729**	**-98,215**	**419,438**

1/ These proposals are described in the Program Integrity chapter, which reports the total cost of the proposal to both Medicare and Medicaid.
2/ These proposals are described in the Medicaid chapter, which reports the total cost of the proposal to both Medicare and Medicaid.
3/ Adjusts for reductions in baseline IPAB savings as a result of budget proposals and other Medicare interactions.
4/ This total does not include non-PAYGO savings.

PROGRAM INTEGRITY

The FY 2017 budget supports fraud prevention and the reduction of improper payments, which are top priorities of the Administration. For FY 2017, the budget proposes $199 million in new mandatory and discretionary investments to address health care fraud, waste and abuse. Together, the program integrity investments in the budget will yield $23.8 billion in savings for Medicare and Medicaid over 10 years. The budget also proposes legislative changes to give HHS important new tools to enhance program integrity oversight and cut fraud, waste, and abuse in Medicare, Medicaid and the Children's Health Insurance Program.

MEDICAID

FY 2017, more than 70 million people on average will receive health care coverage through Medicaid. In FY 2017, the federal share of current law Medicaid outlays are expected to be approximately $376.6 billion.

The FY 2017 budget includes a package of Medicaid legislative proposals with a net impact to the federal government of $22.2 billion over 10 years by investing in delivery system reform efforts and improving access to high-quality and cost-effective coverage and services for Medicaid beneficiaries. The budget also strengthens Medicaid drug coverage and reimbursement, and bolsters Medicaid program integrity efforts. Finally, the budget includes proposals that impact those who are dually eligible for both Medicare and Medicaid.

FY 2017 MEDICAID LEGISLATIVE PROPOSALS

Dollars in Millions	2017	2017-2021	2017-2026
Support Delivery System Reform			
Reestablish the Medicaid Primary Care Payment Increase Through CY 2017 and Include Additional Providers	7,610	9,510	9,510
Add Certain Behavioral Health Providers to the Electronic Health Record Incentive Programs (Medicaid Impact)	—	3,800	4,440
Pilot Comprehensive Long-Term Care State Plan Option	0	3,181	4,054
Expand Eligibility Under the Community First Choice Option	255	1,582	3,866
Provide Home and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities	—	584	1,609
Allow States to Develop Age-Specific Health Home Programs	210	690	1,100
Expand Eligibility for the 1915(i) Homes and Community-Based Services State Plan Option	7	124	374
Allow Full Medicaid Benefits to All Individuals in a Home and Community			
Based Services (HCBS) State Plan Option	—	4	9
Improve Access to Coverage and Services			
Create State Option to Provide 12-Month Continuous Medicaid Eligibility for Adults (non-add) /1	467	4,731	11,135
Medicaid Impact	800	13,000	34,900
Treasury Impact (non-add)	-333	-8,269	-23,765
Strengthen Medicaid in Puerto Rico and the U.S. Territories	320	9,315	29,644
Extend Enhanced Federal Match for New Medicaid Expansion States	430	2,300	2,610
Permanently Extend Express Lane Eligibility Option for Children		235	870
Require Full Coverage of Preventive Health and Tobacco Cessation Services for Adults in Traditional Medicaid	99	450	789
Create Demonstration to Address Over-Prescription of Psychotropic Medications for Foster Care Children /2	119	624	567
Require Coverage of Early and Periodic Screening, Diagnostic, and Treatment for Children in Inpatient Psychiatric Treatment Facilities	35	215	505
Provide Full Medicaid Coverage to Pregnant and Postpartum Beneficiaries	30	165	375

continued

Dollars in Millions	2017	2017-2021	2017-2026
Extend 100 Percent Federal Match to All Indian Health Programs	6	34	80
Expand State Flexibility to Provide Benchmark Benefit Packages	—	—	—
Streamline Certain Medicaid Appeals Processes	—	—	—
Improve Quality and Cost-Effectiveness			
Extend Funding for the Adult Health Quality Measures Program (non-add)/3	14	70	70
Require Remittances for Medical Loss Ratios for Medicaid and CHIP Managed Care	—	-5,100	-23,500
Rebase Future Medicaid Disproportionate Share Hospital Allotments	0	0	-6,640
Strengthen Medicaid Drug Coverage and Reimbursement			
Create a Federal-State Medicaid Negotiating Pool for High-Cost Drugs	-200	-2,510	-5,830
Lower Medicaid Drug Costs and Strengthen the Medicaid Drug Rebate Program	-481	-2,670	-5,616
Correct the Affordable Care Act Medicaid Rebate Formula for New Drug Formulations and Exempt Abuse Deterrent Formulations (non-add)	-410	-2,085	-4,285
Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits (non-add)	-30	-370	-870
Clarify the Definition of Brand Drugs to Prevent Inappropriately Low Rebates (non-add)	-21	-115	-260
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations (non-add)	-20	-100	-200
Exempt Emergency Drug Supply Programs from Medicaid Drug Rebate Calculation (non-add)	—	—	—
Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters (non-add)	—	—	—
Require Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program (non-add)	—	—	—
Strengthen the Integrity of the Medicaid Program			
Promote Program Integrity for Medicaid Drug Coverage	—	—	—
Enforce Manufacturer Compliance with Drug Rebate Requirements			
(non-add)	—	—	—
Increase Penalties on Drug Manufacturers for Fraudulent Noncompliance			
with Medicaid Drug Rebate Agreements (non-add)	—	—	—
Require Drugs be Properly Listed with FDA to Receive Medicaid Coverage			
(non-add)	—	—	—
Require Manufacturers that Improperly Report Items for Medicaid Drug			
Coverage to Fully Repay States (non-add)	—	—	—
Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS			
(non-add)	—	—	—

continued

Dollars in Millions	2017	2017-2021	2017-2026
Cut Fraud, Waste, Abuse, and Improper Payments in Medicaid /4	-32	-330	-790
Total Outlays, Medicaid Proposals	**9,208**	**35,204**	**52,927**
Medicare-Medicaid Enrollee Proposals			
Improve Alignment of Medicare Savings Program and Part D Low-Income Subsidy Income and Asset Definitions	31	169	394
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries (Medicare Impact) (non-add)	—	20	100
Allow for Federal/State Coordinated Review of Dual Special Need Plan			
Marketing Materials	—	—	—
Integrate Appeals Process for Medicare-Medicaid Enrollees	—	—	—
Total Outlays, Medicare-Medicaid Enrollee Proposals	**31**	**169**	**394**
Medicaid Interactions			
Provide States Option to Eliminate Medicaid Assignment of Cash Medical Support /5	—	36	162
Extend Special Immigrant Visa Program /6	—	32	65
Expand the Certified Community Behavioral Health Clinic Demonstration /7	20	110	110
Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees /8	12	25	25
Extend CHIP Funding through 2019 /9	—	-5,560	-5,560
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics /10	-120	-620	-1,380
Eliminate the 190-Day Lifetime Limit on Inpatient Psychiatric Facility Services /10	-50	-310	-720
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics /10	—	-30	-130
Eliminate Medicaid Recoupment of Birthing Costs from Child Support /5	—	—	—
Establish Hold-Harmless for Federal Poverty Guidelines	—	—	—
Total Outlays, Medicaid Interactions	**-138**	**-6,307**	**-7,368**
Total Outlays, Medicaid Legislative Proposals	**9,100**	**29,065**	**45,953**
Total Outlays, Total Federal Impact /11	**8,767**	**20,796**	**22,188**

1/ The score reflects the impact on both Medicaid and U.S. Department of Treasury programs.
2/ This is a joint proposal with the Administration for Children and Families (ACF). The score reflects the impact on the Medicaid baseline. Please see the ACF and State Grants and Demonstration chapters for more information on this proposal.
3/ This proposal reflects costs to the Program Management account. See the Program Management chapter for more information.
4/ This includes proposals described in the Program Integrity chapter, excluding savings not subject to PAYGO and excluding the proposal to Expand Funding for the Medicaid Integrity Program, which is described in the Program Integrity chapter but accounted for in the tables in the State Grants and Demonstrations chapter.
5/ This proposal is included in the Administration for Children and Families' FY 2017 Budget Request.
6/ This proposal is included in the State Department's FY 2017 Budget Request. Total excludes $4 million in Medicaid outlays in FY 2017 due to a proposed change in a mandatory program for a Department of State proposal.
7/ This proposal is part of the Administration's broader investments to expand mental health described in the Budget in Brief overview.

continued

8/ This proposal is included in the Social Security Administration's FY 2017 Budget Request.
9/ See Children's Health Insurance Program (CHIP) chapter for proposal description.
10/ See Medicare chapter for proposal description.
11/ The total federal impact reflects $23.8 billion in savings to the Marketplace subsidies and related impacts included in the Department of Treasury programs and accounts.
Note: Numbers may not add due to rounding

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting