



Centers for Medicare & Medicaid Services: President's FY2014 Budget

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Summary

Federal law requires the President to submit an annual budget 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 may also 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 are generally included in the budget. President Obama submitted his FY2014 budget to Congress on April 10, 2013.

The Centers for Medicare & Medicaid Services (CMS) is the division of the Department of Health and Human Services (HHS) that is responsible for administering Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP), among other activities. CMS is the largest purchaser of health care in the United States, with expenditures from CMS programs accounting for roughly one-third of the nation's health expenditures. In FY2014, it is estimated that one-in-three Americans will be provided coverage through Medicare, Medicaid, and CHIP. CMS is also responsible for implementing many of the private health insurance provisions in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148).

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 benefits and grants to states for Medicaid.

For budgetary purposes, CMS is divided into the following sections: Medicare, Medicaid, CHIP, program integrity, state grants and demonstrations, private health insurance protections and programs, the Center for Medicare and Medicaid Innovation, and program management. The President's FY2014 budget contains a number of legislative proposals that would affect the CMS budget. Some are program expansions, and others are designed to reduce federal spending.

The President's proposed budget for CMS would be \$854.3 billion in net mandatory and discretionary outlays for FY2014. This would be an increase of \$60.2 billion, or 7.6%, over the net outlays for FY2013. This estimate includes the cost of the Medicare physician payment adjustment (\$15.4 billion), the estimated savings of the legislative proposals (-\$5.8 billion), and the estimated savings from program integrity investments (-\$0.1 billion).

This report summarizes the President's budget estimates for 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 proposal. The explanations of the President's legislative proposals are grouped by the following program areas: Medicare, Medicaid, program integrity, private health insurance, and program management. A table summarizing the estimated costs or savings for each legislative proposal is at the end of each of these sections.

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Introduction

Federal law requires the President to submit an annual budget 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 may also 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 are generally included in the budget. President Obama submitted his FY2014 budget to Congress on April 10, 2013.

The Centers for Medicare & Medicaid Services (CMS) is the division of the Department of Health and Human Services (HHS) that is responsible for administering Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). In January 2011, CMS became responsible for much of the implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) when the Center for Consumer Information and Insurance Oversight (CCIIO) was established within CMS.²

CMS is the largest purchaser of health care in the United States with Medicare and federal Medicaid expenditures accounting for 29.7% of the total national health expenditures in 2011.³ In 2010, CMS provided health insurance to 114 million individuals through Medicare, Medicaid and CHIP, which is roughly one in three Americans.⁴

This report summarizes the President's budget estimates for 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 proposal. The explanations of the President's legislative proposals are grouped by the following program areas: Medicare, Medicaid, program integrity, private health insurance, and program management. At the end of each of these sections, there is a table summarizing the estimated costs or savings for each legislative proposal.

¹ 31 U.S.C. 1105(a).

² The action taken to establish the Center for Consumer Information & Insurance Oversight also closed the Office of Consumer Information and Insurance Oversight. Department of Health and Human Services' Centers for Medicare & Medicaid Services, "Statement of Organization, Functions, and Delegations of Authority," 76 *Federal Register* 4703, January 26, 2011.

³ Centers for Medicare & Medicaid Services, National Health Expenditures Data, Historic Tables, January 9, 2013.

⁴ Medicare-Medicaid Coordination Office, *Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011*, February 2013; Medicaid and CHIP Payment and Access Commission, *Report to Congress*, March 2011; Medicaid and CHIP Payment and Access Commission, *Report to Congress*, March 2013.

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: 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 (name redacted)

Budget Summary

The CMS budget includes a mixture of both mandatory and discretionary spending. However, a vast majority of the CMS budget is mandatory spending, such as Medicare benefits and grants to states for Medicaid.

The President's budget estimates that under current law CMS mandatory and discretionary net outlays would amount to \$845.5 billion in FY2014.⁵ This is an increase of \$51.2 billion, or 6.4%, over the estimated net outlays for FY2013.⁶

The President's FY2014 budget increases the baseline for Medicare spending by assuming that Congress will block a proposed reduction in physician payments. The President's budget estimates this adjustment will increase CMS's net outlays by \$15.4 billion in FY2014. With this adjustment, CMS's total net outlays are estimated to be \$860.9 billion in FY2014.

The President's FY2014 budget proposes to make a number of legislative changes to Medicare, Medicaid, program integrity, private health insurance, and program management. The President's budget estimates that if these legislative proposals were implemented, CMS's total net outlays would increase by \$0.3 billion in FY2013 and decrease by \$5.8 billion in FY2014.

⁵ The figures in this document are taken from the following two documents: Department of Health and Human Services, Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans (<http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>) and Department of Health and Human Services' Centers for Medicare & Medicaid Services, Fiscal Year 2014 Justification of Estimates for Appropriations Committees (<http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf>).

⁶ At the time the President's FY2014 budget proposal was developed, none of the full-year appropriations bills for FY2013 were enacted. As a result, the programs and activities normally provided for in the full-year appropriations bills were operating under the Continuing Appropriations Resolution, 2013 (P.L. 112-175). For these programs and activities, full-year appropriations data for FY2013 reflect the annualized level provided by P.L. 112-175 rather than the Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6), which was signed into law on March 26, 2013.

With the Medicare physician payment adjustment, the estimated impact of the legislative proposals, and the estimated savings net of the program integrity and Health Care Fraud and Abuse Control (HCFAC) investments (\$0.4 billion), the President's budget estimates CMS's net outlays will be \$854.3 billion in FY2014, which is an increase of \$60.2 billion, or 7.6%, over the net outlays for FY2013.

For budgetary purposes, CMS is divided into the following sections: Medicare, Medicaid, CHIP, program integrity, state grants and demonstrations, private health insurance, the Center for Medicare and Medicaid Innovation (CMMI), and program management. The President's budget estimates for each of these budget sections are summarized below.

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 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. 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.⁷

The President's FY2014 budget estimates that under current law Medicare outlays net of offsetting receipts will be \$522.1 billion in FY2014 (see **Table 1**). The President's budget makes adjustments to the baseline assuming Congressional action preventing a reduction in Medicare physician payments,⁸ which increases the FY2014 baseline outlays net offsetting receipts by \$15.4 billion. The budget includes a number of legislative proposals for Medicare. If implemented, these legislative proposals are estimated to decrease Medicare outlays by \$6.0 billion during FY2014 and \$371.0 billion over the next 10 years.⁹ 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 FY2014 will be \$531.5 billion, which is an increase of \$20.0 billion, or 3.9%, over the estimated net outlays for FY2013.

⁷ For more information about the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and (name redacted).

⁸ For more information about Medicare physician payments, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by (name redacted) and (name redacted).

⁹ The \$6.0 billion in savings is comprised of \$6.1 billion in savings from the legislative proposals impacting the Medicare program and legislative proposals impacting program management activities that are estimated to cost \$0.1 billion.

Table I. President's FY2014 Budget for the Centers for Medicare & Medicaid Services

(dollars in billions)

	FY2012	FY2013 ^a	FY2014	FY2013-FY2014	
				\$ Change	% Change
Medicare					
Current Law	\$472.0	\$511.5	\$522.1	\$10.7	2.1%
Adjustments	0.0	0.0	15.4		
Legislative Proposals net Offsetting Receipts ^b	0.0	0.0	-6.0		
Subtotal	472.0	511.5	531.5	20.0	3.9%
Medicaid					
Current Law	250.5	266.6	303.8	37.2	14.0%
Legislative Proposals ^c	0.0	0.0	-0.1		
Subtotal	250.5	266.6	303.7	37.1	13.9%
CHIP					
Current Law ^d	9.1	10.0	10.1	0.1	0.7%
State Grants and Demonstrations					
Current Law	0.5	0.8	0.7	-0.0 ^e	-4.9%
Private Health Insurance Protections and Programs					
Current Law	3.7	4.1	7.3	3.2	76.4%
Legislative Proposals	0.0	0.0	0.0		
Subtotal	3.7	4.1	7.3	3.2	76.4%
CMMI					
Current Law	0.8	1.3	1.4	0.1	7.6%
Savings from Program Integrity ^f	0.0	-0.2	-0.4	-0.2	
Total Net Outlays, Proposed Law	\$736.6	\$794.1	\$854.3	\$60.2	7.6%

Source: Table created by CRS based on data from the Department of Health and Human Services, Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans, <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>.

Notes: Funding for program management activities is built into this table. Totals may not add due to rounding.

- a. The FY2013 figures represent the annualized funding levels provided by the Continuing Appropriations Act through March 27, 2013 (P.L. 112-175) and do not reflect the cuts required by sequestration. The FY 2013 and FY 2014 mandatory figures reflect current law and mandatory proposals reflected in the Budget.
- b. The \$6.0 billion in savings includes \$6.1 billion for Medicare legislative proposals net of premiums and offsetting receipts, in addition to the cost of \$0.1 billion for Program Management legislative proposals.
- c. Includes impact of program integrity proposals, which are estimated to result in \$156 million in savings for the Medicaid program in FY2014.
- d. Includes Child Enrollment Contingency Fund.
- e. Savings of \$40 million.
- f. Includes non-PAYGO scorecard savings from additional investments in Health Care Fraud and Abuse Control and Social Security disability reviews, above savings already assumed in current law.

The “Medicare Legislative Proposals” section below includes a description of each legislative proposal pertaining to the Medicare program. This section includes an explanation of current law and each of the President’s legislative proposals. At the end of the section, there is a table summarizing the costs or savings for each of the President’s legislative proposals.

Medicare Quality Improvement Organizations (QIOs)

CMS contracts with private organizations, now known as QIOs, to improve efficiency, effectiveness, economy, and quality of services delivered to Medicare beneficiaries. CMS contracts with one organization in each state, the District of Columbia, Puerto Rico, and other jurisdictions to serve as a QIO contractor to perform a range of activities. The QIO’s most recent contract cycle or 10th Statement of Work (SOW) began August 1, 2011 and will end July 31, 2014. The 10th SOW provides \$1.6 billion in funding over the three year timeframe, and this funding is used to fund clinical quality improvement priorities (\$449.3 million), beneficiary center care (\$181.0 million), value based purchasing support (\$404.2 million), infrastructure and other special initiatives (\$405.4 million), and other support contracts (\$207.6 million).

The 11th SOW begins August 1, 2014, and this SOW will implement certain changes to the QIO program that were included as part of the Trade Adjustment Assistance Extension Act of 2011 (which was incorporated into the bill to extend the Generalized Systems of Preferences and for other purposes, P.L. 112-40). These changes include providing flexibility to determine the geographic scope of a QIO contract, permitting contracts with a broader range of entities, awarding certain QIO tasks to specialty contractors, terminating QIO contracts for poor performance among other changes, and extending the length of the existing three year contract to five years.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care.¹⁰ Medicaid is jointly funded by the federal government and the states. Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and the territories choose to participate. Each state designs and administers its own version of Medicaid under broad federal rules. While states that choose to participate in Medicaid must comply with all federal mandated requirements, state variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are reimbursed and delivered. Historically, eligibility was generally limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities; however, recent changes will soon add coverage for individuals under the age of 65 with income up to 133% of the federal poverty level (FPL).¹¹ The federal government pays a share of each

¹⁰ For more information about the Medicaid program, see CRS Report RL33202, *Medicaid: A Primer*, by (name redacted).

¹¹ The Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) establishes 133% of FPL based on modified adjusted gross income as the new mandatory minimum Medicaid income eligibility level starting in 2014. On June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business (NFIB) v. Sebelius* finding that the federal government cannot terminate the federal Medicaid funding a state receives for its current Medicaid program if a state refuses to implement the ACA Medicaid expansion. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules. However, based on the Court’s opinion, it appears that a state can refuse to participate in the ACA Medicaid expansion without losing any of (continued...)

state's Medicaid costs; states must contribute the remaining portion in order to qualify for federal funds.¹²

The President's FY2014 budget estimates that under current law Medicaid total net outlays will amount to \$303.8 billion, which is an increase of \$37.2 billion, or 14.0%, over estimated net outlays for FY2013 (see **Table 1**).¹³ The President's budget includes a number of legislative proposals that would impact Medicaid. If these proposals are implemented, the President's budget estimates that total net outlays for Medicaid would decrease by \$0.1 billion in FY2014 and \$22.1 billion over the next 10 years.¹⁴ Including the estimated impact of the legislative proposals and savings from program integrity investments, the President's budget estimates FY2014 net outlays for Medicaid will amount to \$303.7 billion, which is an increase of \$37.1 billion, or 13.9%, over the estimated net outlays for FY2013.

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. At the end of the section, there is a table summarizing the costs or savings for each of these proposals.

CHIP

The Balanced Budget Act of 1997 (P.L. 105-33) established CHIP to provide health insurance coverage to low-income, uninsured children in families with incomes above applicable Medicaid income standards. Authorization and funding for CHIP has been extended a number of times, and most recently, the ACA extended federal funding for CHIP through FY2015. CHIP is jointly funded by the federal government and the states, and federal CHIP funding is capped on a state-by-state basis according to annual allotments. In general, CHIP allows states to cover targeted low-income children with no health insurance in families with income above Medicaid eligibility levels. States may also extend CHIP coverage to pregnant women when certain conditions are met.

The President's FY2014 budget estimates that under current law CHIP's total outlays will amount to \$10.1 billion, which is an increase of \$0.1 billion, or 0.7%, over the estimated outlays for FY2013 (see **Table 1**).¹⁵ While there are no specific CHIP legislative proposals, two proposals in

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its current federal Medicaid matching funds.

¹² For more information about Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*, by (name redacted).

¹³ 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 \$36.9 billion, or 14.7%, in FY2014, and outlays for state administration are estimated to increase by \$0.3 billion, or 1.7%, in FY2014.

¹⁴ These figures include the impact of program integrity proposals, which are estimated to result in savings to the Medicaid program of \$156 million in FY2014 and \$3.7 billion over the next 10 years.

¹⁵ The federal CHIP budget consists of outlays for the state allotments and the Child Enrollment Contingency Fund. The Child Enrollment Contingency Fund was added to CHIP in order to prevent states from experiencing shortfalls of federal CHIP funds. This fund receives an appropriation separate from the national CHIP allotment amounts. Direct payments from the Contingency Fund can be made to shortfall states for the federal share of expenditures for CHIP children above a target enrollment level. Payments from the Contingency Fund cannot exceed 20% of that year's national allotment amount and are to be reduced proportionally if necessary. The President's budget estimates outlays for benefits and state administration will increase by \$95 million, or 1.0%, from FY2013 to FY2014, and the Child Enrollment Contingency Fund outlays are estimated to decrease by \$25 million, or 20%, from FY2013 to FY2014.

another part of the CMS budget will have an impact on CHIP. One proposal would prevent the use of federal funds to pay a state's share of Medicaid or CHIP expenditures, and the other proposal would strengthen penalties for illegal distribution of beneficiary identification numbers. These legislative proposals are discussed in the "Program Integrity Legislative Proposals" section of this report.

Program Integrity

Title II of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) established the 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, which 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.

The budget estimates for the program integrity activities are built into the budget summaries discussed above for Medicare and Medicaid. However, when the funding for program integrity activities are broken out, the President's FY2014 budget estimates total budget authority for program integrity activities will amount to \$2.0 billion in FY2014. This is an increase of \$52 million, or 2.7%, over FY2013. Funding for program integrity consists of both mandatory and discretionary funding. In FY2014, the mandatory funding for program integrity activities is estimated to be \$1.7 billion, and the discretionary funding is estimated to be \$0.3 billion.

The "Program Integrity Legislative Proposals" section below includes a description of current and proposed law for each of the program integrity legislative proposals. At the end of the section, there is a table summarizing the costs or savings for each of the President's legislative proposals.

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 following: Money Follows the Person Demonstration, Medicaid Integrity Program, incentives for prevention of chronic diseases in Medicaid, CHIP Outreach and Enrollment Grants, Medicaid Emergency Psychiatric Demonstration, and emergency services for undocumented aliens. The President's budget estimates that under current law FY2014 total outlays for state grants and demonstrations will amount to \$0.7 billion, which is a decrease of \$40 million, or -4.9%, from FY2013 (see **Table 1**). The President's budget does not include any legislative proposals impacting the state grants and demonstrations portion of the CMS budget.

Private Health Insurance Protections and Programs

The ACA includes reforms that focus on restructuring the private health insurance market by creating new programs (e.g., Health Insurance Exchanges) and by imposing requirements on private health insurance plans.¹⁶ Certain reforms require the participation of public agencies and

¹⁶ For more information about the private health insurance protections and programs, see CRS Report R43048, (continued...)

officials in order to facilitate administrative or operational functions. The Center for Consumer Information and Insurance Oversight (CCIIO) within CMS is charged with helping implement the provisions of the ACA related to private health insurance. The President's FY2014 budget proposal includes estimates of the effects of ACA provisions that are currently in effect and the implementation of the health insurance exchanges, which are to be operational and offering coverage on January 1, 2014.

The President's FY2014 budget estimates that under current law FY2014 total outlays for the health insurance programs will amount to \$7.3 billion, which is an increase of \$3.2 billion, or 76.4%, from FY2013 (see **Table 1**). The President's budget includes one legislative proposal that impacts the health insurance program, but the President's budget estimates this proposal will not have a budgetary impact. The "Private Health Insurance Legislative Proposals" section below includes a description of current and proposed law for the President's legislative proposal.

Centers for Medicare & Medicaid Innovation (CMMI)

CMMI was established by Section 3021 of the ACA and 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 CMMI activities from FY2011 through FY2019. CMMI initiatives include Partnership for Patients, Health Care Innovation Awards, Pioneer Accountable Care Organizations (ACO), Advance Payment ACO Model, the Federally-Qualified Health Center Advanced Primary Care Practice demonstration, and state demonstrations to integrate care for dual eligible individuals.

The President's budget estimates that under current law FY2014 total outlays for CMMI will amount to \$1.4 billion, which is an increase of \$0.1 billion, or 7.6%, from FY2013 (see **Table 1**). The President's budget does not include any legislative proposals impacting CMMI.

Program Management

The program management portion of the CMS budget includes funding for the administration of Medicare, Medicaid, CHIP, and other CMS activities. The budget estimates for the program management activities are built into the budget summaries discussed above. However, when the funding for program management activities are broken out, the President's budget estimates that under current law the FY2014 budget for program management activities will be \$6.4 billion. 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 \$0.4 billion in FY2014 and \$0.5 billion over the next 10 years.¹⁷

(...continued)

Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA), by (name redacted), CRS Report R42069 *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted), and CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

¹⁷ The President's budget estimate for CMS's program management activities includes an adjustment for reimbursable administration, which is offsetting collections from non-federal sources that are estimated to be \$1.0 billion in FY2014. This reimbursable administration adjustment includes Health Insurance Exchanges, Clinical Laboratory Improvement (continued...)

Funding for program management consists of both discretionary and mandatory funding. The discretionary funding for program management activities is estimated to be \$5.2 billion in FY2014, which is an increase of \$1.4 billion, or 35.8%, over FY2013 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.

In FY2014, under current law, the mandatory funding for program management activities is estimated to be \$0.3 billion, which is a \$34 million decrease from the FY2013 funding. The President's budget estimate includes legislative proposals that impact program management activities. If these proposals are implemented, the President's budget estimates that mandatory program management funding would increase by \$0.4 billion in FY2014. The legislative proposals impacting program management are discussed in the "Program Management Legislative Proposals" section of the CMS budget.

Including the impact of the legislative proposals, the President's FY2013 budget estimates total program level funding for program management activities would amount to \$6.9 billion in FY2014. This is an increase of \$2.2 billion, or 47.8%, over FY2013.

Legislative Proposals

The President's FY2014 budget contains a number of proposals that would impact the CMS budget. Some 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. This report groups these legislative proposals by program areas: Medicare, Medicaid, program integrity, private health insurance, and program management. At the end of each of these sections, there is a table summarizing the costs or savings for each legislative proposal, and the tables classify each proposal as new, modified from the President's FY2013 budget, or repeated from the President's FY2013 budget.¹⁸

(...continued)

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.

¹⁸ Legislative proposals classified as "repeated" might have different start dates than the FY2013 proposal due to the start date from the FY2013 budget lapsing or legislation having been enacted that impacted the start date from FY2013 budget.

Common Acronyms for Public Laws

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

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

ATRA: The American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240)

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

BIPA: The Benefits Improvement and Protection Act of 2000 (BIPA, incorporated into the Consolidated Appropriations Act of 2001, P.L. 106-554)

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

MCTRJCA: Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)

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

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

MMSEA: The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)

Medicare Legislative Proposals

Medicare Part A

Reduce Medicare Coverage of Bad Debts

Current Law

Medicare reimburses providers for beneficiaries' unpaid coinsurance and deductible amounts after reasonable collection efforts. Historically, Medicare has reimbursed 100% of these bad debts. BBA97 had scheduled bad debt in acute care 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, BIPA froze the reduction at 70% reimbursement in FY2001 and for subsequent years. DRA reduced the payment amount for Medicare-allowable skilled nursing facility (SNF) bad debt from 100% to 70%, except for the bad debt attributable to beneficiaries eligible for both Medicare and Medicaid (i.e., dual eligibles), 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%. Other Medicare providers that receive bad debt reimbursement are: critical access hospitals, rural health clinics, federally qualified health clinics, community mental health clinics, dialysis facilities, health maintenance organizations reimbursed on a cost basis, competitive medical plans, and health care prepayment plans. The MCTRJCA reduced Medicare bad debt reimbursement to 65% for all providers. Providers who were reimbursed at 70% would receive 65% bad debt reimbursement beginning in FY2013. Other providers who were reimbursed at 100% of bad debt are reimbursed at 88% in FY2013 and will be reimbursed at 76% in FY2014 and 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 FY2014 for all providers that receive bad debt payments. **This proposal was included in the President's FY2013 budget proposal.**

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 (IME) payments are calculated as a percentage increase to Medicare's inpatient payment rates. The IME 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 IME 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 IME payments can be empirically justified. In its June 2010 report, MedPAC recommended that Medicare's funding of graduate medical education be changed to support necessary workforce skills and that the Secretary of HHS, henceforth referred to a Secretary, set standards for receiving such funds.

President's Proposal

The President's budget would reduce IME funding by a total of 10%, starting in FY2014. The Secretary would be given the authority to set standards for teaching hospitals to encourage the training of primary care residents and develop necessary workforce skills. **This proposal was included in the President's FY2013 budget proposal.**

Reduce Critical Access Hospital Reimbursements to 100% of 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 a necessary provider, 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 fixed-fee payments paid to acute care hospitals under the Medicare's prospective payment systems (PPS). Since FY2004, CAHs receive 101% of reasonable, cost-based reimbursement for inpatient care, outpatient care, ambulance services, and skilled nursing facility 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 FY2014. **This proposal was included in the President's FY2013 budget proposal.**

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

Current Law

In order 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 determined to be necessary providers. Existing necessary providers maintained their status as CAHs.

President's Proposal

The President's budget would rescind state's ability to waive federal mileage requirements for entities less than 10 miles from another hospital or CAH, thus eliminating their Medicare enhanced payment beginning in FY2014. **This proposal was included in the President's FY2013 budget proposal.**

Adjust Payment Updates for Certain Post-Acute Care Providers

Current Law

MedPAC has found that Medicare payments generally exceed providers' costs for post-acute services. Each year, MedPAC makes recommendations for provider payment increases for the next fiscal or rate year. In its March 2013 report, MedPAC recommended that the Medicare payment updates for SNFs, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs), and home health agencies (HHAs) be eliminated for the upcoming year. MedPAC projected the 2013 aggregate Medicare margin (the amount that Medicare payments exceed costs) to be 12% and 14% for SNFs, 8.5% for IRFs, 5.9% for LTCHs, and 11.8% for HHAs. The ACA amended the annual update policy for these post-acute providers to include an adjustment to account for economy-wide productivity increases for cost savings.¹⁹ The productivity adjustment for SNFs, IRFs and LTCHs was implemented on October 1, 2011. The productivity adjustment for HHAs will be implemented on January 1, 2015. The annual updates for IRFs, HHAs, and LTCHs are subject to other reductions as well. The amount and the timing of such reductions vary

¹⁹ Productivity, in general, is a measure of output relative to the amount of work required to produce it. The ACA adjusts Medicare's annual payment updates to account for economy-wide productivity increases, thus providing additional cost savings to the Medicare program.

by provider. Every post-acute provider may have an update less than 0.0 which would result in lower payment rate than in the preceding year.

President's Proposal

The President's budget would implement additional update reductions for these post-acute providers (i.e., IRFs, LTCHs, SNFs, and HHAs) of 1.1 percentage points from FY2014 through FY2023. Payment updates for these providers would not drop below 0.0 due to the 1.1 percentage point reduction. **This proposal was included in the President's FY2013 budget proposal.**

Encourage Appropriate Use of Inpatient Rehabilitation Facilities

Current Law

IRFs are either freestanding hospitals or distinct units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS), 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 in order to be considered IRFs. Starting October 1, 1983, CMS has required that a facility must treat a certain proportion of patients with specified medical conditions in order to qualify as an IRF and receive higher Medicare payments. IRFs were required to meet the "75 percent 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 pre-established 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 at 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 MMSEA, 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 FY2014. **This proposal was included in the President's FY2013 budget proposal.**

Equalize Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities

Current Law

Patients receiving treatment for certain conditions such as hip and knee replacements can receive rehabilitative care in a variety of post-acute care settings, including SNFs and IRFs. Generally, care provided in an IRF is paid at a higher rate than care provided in a SNF.

President's Proposal

The President's budget would adjust reimbursement rates in the different post-acute care settings for certain overlapping conditions treated in multiple settings. Beginning in FY2014, the proposal would limit payment differentials for three conditions involving hips and knees, pulmonary conditions, as well as additional conditions the Secretary considers applicable. IRFs that provide intensive rehabilitation services to patients with relatively uncomplicated conditions would be paid as SNFs. **This proposal was included in the President's FY2013 budget proposal.**

Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions

Current Law

As established by the ACA, acute care hospitals with relatively high readmission rates are subject to penalties starting in FY2013. The penalties are capped at 1% of the Medicare payment in FY2013, at 2% in FY2014, and at 3% in FY2015 and beyond. SNFs with high readmission rates are not subject to such penalties. In its March 2012 report, MedPAC recommended that Congress reduce Medicare payments to SNFs with relatively high risk-adjusted rehospitalization rates to improve care coordination across different health care settings.

President's Proposal

The President's budget would reduce payments to SNFs with high rates of preventable hospital readmissions by up to 3% beginning in FY2017. **This proposal was included in the President's FY2013 budget proposal.**

Implement Bundled Payment for Post-Acute Care Providers

Current Law

Post-acute care services primarily include nursing and rehabilitation services following a beneficiary's inpatient hospital stay. These services can be offered in institutional settings, such as LTCHs, IRFs, SNFs, as well as in community-settings by HHAs. Many post-acute care providers furnish similar services; however, Medicare payment rates are not the same across settings due to different provider cost structures and unique Medicare payment system differences. Use of post-acute care services is dramatically different across states. The Institute of Medicine (IOM) 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, MedPAC's June 2008 report suggested a single predetermined payment for an episode of care that includes the beneficiary's inpatient hospital stay as well as physician services, post-acute care services, and any hospital readmissions. The details of MedPAC's bundled payment proposal are still under development; however, CMS recently launched a Bundled Payment for Care Improvements (BPCI) Initiative to test different bundling payment models. In Model 2 of the BPCI, participants in the initiative will manage a beneficiary's episode (either 30, 60, or 90 days) that includes the acute-care hospital services, physician services, and post-acute care services. Participants that

achieve a reduction in episode spending when compared to a pre-determined spending benchmark will be allowed to share in the savings.

President's Proposal

The President's budget would implement a bundled payment for post-acute care providers (LTCHs, IRFs, SNFs, and HHAs) beginning in FY2018. The bundled payment would be based on patient characteristics and other factors and be set to reduce Medicare expenditures by 2.85% by FY2020. Payments would be bundled for at least half of the total payments for post-acute care providers, but little detail was provided about how this would work. **This proposal was *not* included in the President's FY2013 budget proposal.**

Clarify the Medicare Disproportionate Share Hospital (DSH) Statute

Current Law

Medicare DSH funds are paid to qualifying hospitals through an adjustment within the applicable PPS. Generally, DSH hospitals receive the additional payments based on a DSH patient percentage (DPP) which is the sum of two fractions. The Medicare fraction is calculated by dividing the number of hospital inpatient days provided to patients who are eligible for Supplemental Security Income (SSI) and entitled to Medicare Part A benefits divided by the total number of hospital days provided to patients who are entitled to Medicare Part A benefits. This is added to the Medicaid fraction which is calculated as the number of hospital days for patients who (for such days) are eligible for medical assistance under an approved state Medicaid plan and who are not entitled to Part A benefits divided by the total number of hospital 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.

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 should be included in the Medicare fraction of the hospitals' DSH DPP calculation. **This proposal was *not* included in the President's FY2013 budget proposal.**

Medicare Part B

Reduce Overpayment of Part B Drugs

Current Law

Medicare covers certain drugs (i.e., drugs provided in physicians' offices and normally administered by physicians) under Medicare Part B, rather than under Medicare's Part D outpatient prescription drug benefit. Medicare reimburses physicians for most Part B drugs based on the formula of 106% of the manufacturer's Average Sales Price (ASP) for each drug,

regardless of the price at which physicians are able to purchase the drug.²⁰ Physicians negotiate with drug wholesalers, pharmaceutical manufacturers, and other entities to purchase Part B drugs. Large physician practices or hospital outpatient departments that can purchase Part B drugs in larger volumes often are able to get prices considerably lower than 106% of ASP, thereby earning profit each time they administer the drug. Smaller physician practices and other lower volume purchasers are unable to receive comparable discounts to the higher volume purchasers, so they make less profit and may sometimes lose money on Part B drug transactions.

President's Proposal

The President's budget would reduce Medicare Part B drug reimbursements to providers (i.e., physicians, hospital outpatient departments, clinics, and other entities) from 106% of the manufacturer ASP to 103% of ASP. The drug manufacturers would be required to pay a rebate for some drugs in certain instances as determined by the Secretary. **This proposal was *not* included in the President's FY2013 budget proposal.**

Modernize Payments for Clinical Laboratory Services

Current Law

Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are updated for each calendar year. There is a ceiling on each payment amount set at 74% of the median of all fee schedule amounts for that laboratory test. Generally, the Secretary is required to adjust payments annually by the percentage change in the consumer price index for all urban consumers (CPI-U) together with other adjustments as the Secretary deems appropriate. Updates were eliminated for 1998 through 2002, and MMA eliminated updates for 2004-2008. Under current law, the annual clinical laboratory test fee schedule update adjustment for 2009-2013 is the percentage change in the CPI-U minus 0.5 percentage points.

President's Proposal

The President's budget would lower the payment rates under the Clinical Laboratory Fee Schedule (CLFS) by -1.75 percent every year from 2016 through 2023. The proposal would also provide the Secretary with the authority to adjust payment rates under the CLFS in a budget-neutral manner, precluding administrative or judicial review of these adjustments. Additionally, the proposal would support policies to encourage electronic reporting of laboratory results. **This proposal was *not* included in the President's FY2013 budget proposal.**

²⁰ See Social Security Act Sec. 1847A, Use of Average Sales Price Payment Methodology. Medicare pays for some Part B drugs based on 95% of the Average Wholesale Price (AWP). AWP is a published price analogous to a list price. Part B drugs paid for based on AWP include blood clotting factors, drugs furnished through durable medical equipment, and vaccines.

Exclude Certain Services from the In-Office Ancillary Services Exception

Current Law

Limitations on physician self-referrals were enacted into law in 1989 under the Ethics in Patient Referrals Act, commonly referred to as the “Stark law.”²¹ The Stark law, as amended, and its implementing regulations prohibit certain physician self-referrals for designated health services (DHS)²² 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 DHS 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 DHS furnished pursuant to a prohibited referral. It has been noted that the general idea behind the self-referral prohibitions is to limit physicians from making referrals based on financial gain, thus preventing overutilization and increases in health care costs.²³

The Stark law includes a general exception permitting physicians and group practices to order and provide certain DHS in their offices when they meet certain statutory requirements. Although it 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 this exception promotes the overuse of these services.

President's Proposal

Beginning in 2015, this proposal would exclude radiation therapy, therapy services, and advanced imaging from the in-office ancillary services exception to the Stark law, except when a practice meets certain accountability standards, as defined by the Secretary. **This proposal was *not* included in the President's FY2013 budget proposal.**

²¹ The Stark law, created as Section 1877 of the Social Security Act and codified at 42 U.S.C. §1395nn, was created by the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, 103 Stat. 2423 (1989). The Stark law was significantly amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, §13562, 107 Stat. 312 (1993) and is referred to as “Stark II.” Regulations for Stark II have been issued by the Centers for Medicare & Medicaid Services (CMS) and are comprehensive. *See* 42 C.F.R. §411.350 et seq.

²² 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.

²³ *See, e.g.*, 66 Fed. Reg. 856, 859 (Jan. 4, 2001) (“Prior to enactment of [the Stark law], there were a number of studies, primarily in academic literature, that consistently found that physicians who had ownership or investment interests in entities to which they referred ordered more services than physicians without those financial relationships.... Increased utilization occurred whether the physician owned shares in a separate company that provided ancillary services or owned the equipment and provided the services as part of his or her medical practice. This correlation between financial ties and increased utilization was the impetus for ... the Act.”).

Modify Part B Deductible for New Enrollees

Current Law

In addition to paying monthly premiums for Medicare Part B, Medicare beneficiaries also 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. MMA 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 over beginning with 2006 (rounded to the nearest \$1).²⁴ The 2013 Part B annual deductible is \$147.

President's Proposal

The President's budget would increase the annual deductible by an additional \$25 in 2017, 2019, and 2021 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 in the second. The first group, comprised of beneficiaries who enroll in Medicare prior to January 1, 2017, would not be affected by this proposal and their annual Part B deductible would continue to be adjusted each year according to the current methodology. The deductible for Medicare beneficiaries in the second group, those who enroll in Medicare beginning in January 1, 2017 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 2017, another \$25 increase in 2019, and a third \$25 increase in 2021. For example, in a scenario under which the deductible amount remained the same through 2021 (unlikely), in 2021, new beneficiaries would pay a \$75 higher deductible than those who had been enrolled in Medicare prior to 2017. 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 higher than \$75. **This proposal was included in the President's FY2013 budget proposal.**

Introduce Home Health Copayments 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, 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 (P.L. 92-603 and P.L. 96-499) 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 copayments associated with Medicare-

²⁴ Methodology and updates for 2013 detailed Centers for Medicare & Medicaid Services, "Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2013," 77 *Federal Register* 69850, November 21, 2012.

covered durable medical equipment and osteoporosis drugs provided during a home health episode of care. In its March 2013 report, MedPAC recommended that Congress establish a per episode copayment for home health episodes that are not preceded by hospitalization or post-acute care use.

President's Proposal

Beginning in FY2017, the President's budget would institute a \$100 copayment 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 FY2013 budget proposal.**

Introduce Part B Premium Surcharge for New Beneficiaries that 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 may also include additional items or services not covered by Medicare, such as foreign travel. 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. While the federal government does not contribute to Medigap premiums, former employers may make contributions.

There are 10 standardized Medigap plans with varying levels of coverage. Two of the 10 standardized plans cover Parts A and B deductible and coinsurance in full (i.e., offer "first-dollar" coverage). In 2010, over 60% of all Medigap beneficiaries were covered by one of these two plans.

President's Proposal

Beginning in FY2017, the President's budget would impose a Part B premium surcharge for new Medicare beneficiaries who select a Medigap plan with low cost-sharing requirements (i.e., offer "near first-dollar" coverage). 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 FY2013 budget proposal.**

Medicare Parts A and B

Increase Income-Related Premiums Under Part B and Part D

Current Law

Most Medicare beneficiaries pay Part B premiums which are set at 25% of the program's estimated (projected) costs per aged enrollee (i.e., enrollees who are age 65 or older). Since January 2007, higher-income beneficiaries pay a larger share of premiums—35%, 50%, 65%, or 80%, depending on income. In 2010, 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 also imposed a similar income-related premium for Part D services. In addition, the ACA suspended inflation-indexing of income thresholds for Parts B and D through 2019 at 2010 levels. In 2011, about 4% of current Part B enrollees were estimated to pay these higher income-related premiums.

President's Proposal

Beginning in FY2017, 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 would also further suspend inflation-indexing of the income thresholds until 25% of beneficiaries under Parts B and D are subject to these premiums. **This proposal was included in the President's FY2013 budget proposal.**

Medicare Advantage

Increase the Minimum Medicare Advantage Coding Intensity Adjustment

Current Law

Medicare Advantage (MA or Medicare Part C) is an alternative to original fee-for-service Medicare wherein beneficiaries who choose to enroll can receive all Medicare covered benefits (except hospice) through a private health plan such as a health maintenance organization (HMO) or preferred provider organization (PPO). MA plans are paid a per person monthly amount to provide the Medicare covered benefits to enrolled beneficiaries regardless of how many services the beneficiaries actually use. In general, MA plan 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 DRA required the Secretary to adjust MA plan 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 specifies minimum coding intensity adjustments, which were subsequently amended by ATRA. In 2014, the coding intensity adjustment is to be at least the value of the adjustment in

2010 plus 1.5 percentage points; for 2015 to 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 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 2015, the yearly increase to the minimum coding intensity adjustment would be increased from the current law level of 0.25 percentage points to 0.67 percentage points until the minimum adjustment reached a 7.59 percent adjustment in 2018 and would be held at that level thereafter. **This proposal was *not* included in the President's FY2013 budget proposal.**

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

Current Law

Under the Medicare Advantage program, employers and unions may sponsor Medicare Advantage 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 or (EGWPs). Like other MA plans, the EGWPs 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 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 either additional benefits, reduced cost-sharing, reduced Part B or Part D premiums, or some combination of these options. If a plan's bid is equal to or above the benchmark, its payment is the benchmark amount and each enrollee in that plan pays an additional premium, equal to the amount by which the bid exceeds the benchmark.

President's Proposal

Beginning in payment year 2015, the President's budget would establish payment amounts for EGWPs based on average MA plan bids in each individual market. **This proposal was *not* included in the President's FY2013 budget proposal.**

Medicare Part D

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 60% of eligible Medicare beneficiaries are currently enrolled in Part D. Some 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 2013 an estimated 11.4 million Medicare beneficiaries qualified for low-income subsidies.²⁵ Medicare beneficiaries who qualify for Medicaid based on their income and assets (dual-eligibles), who are recipients of Medicare Savings Programs, or who receive Supplemental Security Income are automatically eligible for the full LIS. Others who do not qualify for one of the above, but who have limited assets and incomes below 150% of FPL may also be eligible for the LIS and receive assistance for some portion of their premium and cost sharing charges. About 40% of Part D enrollees receive the LIS.

Prescription drug coverage is provided through private prescription drug plans (PDPs), which offer only prescription drug coverage, or through MA prescription drug plans 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. Under Medicaid, basic prescription drug rebates are determined by the larger of either a comparison of a drug's quarterly average manufacturers' price (AMP) to the best price for the same period, or a flat percentage (23.1%) of the drug's quarterly AMP. The basic rebate percentage for multi-source, non-innovator and all other drugs is 13% of AMP.²⁶

President's Proposal

Beginning in 2014, the President's budget would require drug manufacturers 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. **This proposal was included in the President's FY2013 budget proposal.**

²⁵ Centers for Medicare & Medicaid Services, *Medicare and Medicaid Statistical Supplement, 2012 Edition*, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2012.html>.

²⁶ States receive a rebate of 17.1% for certain outpatient single source and innovator multiple source drugs. These drugs include clotting factor drugs and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications.

Accelerate Manufacturer Drug Discounts 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 haven’t yet spent enough to qualify for more generous catastrophic coverage—face higher out-of-pocket costs. In 2013, an enrollee in a standard plan pays a \$325 deductible, and 25% coinsurance or copayments on drug spending up to the initial coverage limit of \$2,970.²⁷ Between \$2,970 and the catastrophic threshold of \$6,733.75 – the current coverage gap—a beneficiary faces higher cost sharing.

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 2015. The change would effectively eliminate the coverage gap for brand-name drugs in 2015, though federal generic drug subsidies continue to be phased in through 2020. **This proposal was *not* included in the President’s FY2013 budget proposal.**

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 2013:

²⁷ Total drug spending includes both the 25% beneficiary payment in the standard plan and the 75% cost of the drug borne by the plan.

- 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-pays or coinsurance;
- Full-benefit, dual-eligible LIS beneficiaries with income less than 100% of FPL have a \$1.15 co-pay for generic drugs and \$3.50 for brand-name drugs, until they reach the catastrophic threshold, when their copayment 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 prescription and \$6.60 for a brand-name drug until they reach the catastrophic threshold, when their co-payment is zero.
- 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 of \$2.65 for a generic drug or preferred, multiple-source drug prescription, and \$6.60 for a brand-name drug.

LIS beneficiaries are more likely to have multiple, chronic ailments than other Part D beneficiaries and 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 to non-LIS beneficiaries. In its March 2012 report, MedPAC found that, in 2009, non-LIS enrollees had a generic dispensing rate of 72% compared to 68% for LIS enrollees. 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.²⁸

President's Proposal

The President's budget proposes reducing co-payments for generic drugs by more than 15%, to 90 cents per prescription, for LIS beneficiaries with incomes below 100% of poverty, and to \$1.80 for beneficiaries with incomes below 135% of FPL. At the same time, the proposal would double co-payments for brand-name drugs to twice the level under current law. The Secretary would have discretion to exclude certain therapeutic classes of drugs if generic substitution was not clinically appropriate or a generic substitute was not available. LIS beneficiaries could also submit an appeal to continue buying drugs at the current rates.

The proposed cost-sharing change would not apply to LIS beneficiaries who are in an institution or receiving certain community-based services. Part D 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 *not* included in the President's FY2013 budget proposal.**

²⁸ There may be other reasons that LIS beneficiaries use more high-cost drugs, including complexity of treatment and the efficacy of certain drugs.

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 LIS for their Part D coverage. First, a determination must be made that they qualify for the assistance; second, they must enroll, or be enrolled, in a specific Part D plan. Some LIS individuals who have not elected a Part D plan are automatically enrolled into one 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 (MSPs), 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.

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 them to plans through the current, random process. This would mean that one plan would serve as the contact point for LIS beneficiaries, who must often seek reimbursement for retroactive drug claims. The single plan would be paid by CMS through an alternative method. **This proposal was not included in the President’s FY2013 budget proposal.** [This proposal impacts both the Medicare and Medicaid budgets.]

Administrative Proposals

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

Current Law

The ACA established IPAB to develop and submit detailed proposals to Congress and the President to reduce Medicare spending. Proposals are to focus primarily on payments to MA and PDP plans and reimbursement rates for certain providers. The Board will be prohibited from developing proposals related to Medicare benefits, eligibility, or financing. Proposals, which will only be required in certain years when the CMS Chief Actuary determines that the projected Medicare per capita growth rate exceeds certain spending targets, 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 February 2013 Medicare baseline, the Congressional Budget Office (CBO) estimated that the conditions for activating the IPAB trigger would not be met in any of the next 10 fiscal years. While the CMS Actuary makes the official determination that would trigger IPAB activity, estimates consistent with those from CBO would mean that the IPAB would have no effect on federal budget outlays in FY2013 through FY2023 under current law.

President's Proposal

The President's budget would lower the target rate applicable for 2020 and after 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 FY2013 budget proposal.**

Establish an Integrated Appeals Process for Medicare-Medicaid Enrollees

Current Law

The Medicare and Medicaid appeal processes differ significantly. Even within Medicare, although the processes are conceptually similar, the appeals process varies depending on whether it is for Medicare Parts A, B, C, or D. These appeal variations can produce confusion, inefficiency, and increased administrative cost for beneficiaries, providers, and states. The difficulty navigating the different appeals processes is especially troublesome for dual eligibles, who are lower-income Medicare beneficiaries who also are eligible for Medicaid.

For dual eligibles, Medicaid is the payer of last resort, meaning that if services are covered by Medicare, Medicare pays for dual eligibles first, and Medicaid is the secondary payer. If services are only covered by Medicaid, then Medicaid is the only and primary payer. Dual eligibles 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. The Medicare and Medicaid appeal process variances are important for dual eligibles because duals might face delays in receiving medical services and may experience care interruptions due to the differences in the appeals processes. In addition, these coordination issues can be expensive for both programs, potentially adding administrative costs and duplicative treatments.

President's Proposal

The President's budget proposes to introduce legislation that would create an integrated Medicare and Medicaid appeals process for dual eligibles. **This proposal was *not* included in the President's FY2013 budget proposal.** [This proposal impacts both the Medicare and Medicaid budgets.]

Other

Expand Medicare Data Sharing 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 required 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

This President's budget would expand the scope of how qualified entities could use Medicare data beyond that of performance measurement. The Administration proposes that entities be allowed 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 *not* included in the President's FY2013 budget proposal.**

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 (ANDA), an expedited marketing approval pathway at the Food and Drug Administration (FDA). An ANDA allows a generic applicant to obtain marketing approval based upon safety and efficacy data provided to the FDA by the brand name firm. The filing of an ANDA with a paragraph IV certification (that the patent is invalid or not infringed) constitutes a "somewhat artificial" act of patent infringement under the act. A 180-day market exclusivity is provided by the FDA to the first paragraph IV filer(s).

Brand name and generic firms engaged in litigation within the Hatch-Waxman statutory framework have sometimes concluded 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 patented pharmaceutical. These arrangements have been termed "reverse payment" agreements or "pay-for-delay" agreements.

President's Proposal

Beginning in FY2014, under the President's budget, the Federal Trade Commission would be authorized 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 FY2013 budget proposal.** [This proposal impacts both the Medicare and Medicaid budgets.]

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) establishes a licensure pathway for competing versions of previously marketed biologics. In particular, the legislation creates a regulatory regime for two types of follow-on biologics, termed “biosimilar” and “interchangeable” biologics. The FDA is afforded 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, applicants that are the first to establish their product is interchangeable with the brand name biologic are provided a term of marketing exclusivity.

President's Proposal

Effective in FY2014, the President's budget would award brand biologics seven years of exclusivity rather than the current 12 years, and there would be no additional exclusivity periods for “minor” changes in product formulations. **This proposal was included in the President's FY2013 Budget.** [This proposal impacts both the Medicare and Medicaid budgets.]

Extend the Qualified Individuals Program

Current Law

The BBA97 required states 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 no additional matching beyond this annual allocation. There were approximately 523,000 QI individuals in CY2011. Since it was first funded in October 1, 1998, the QI program has been extended 13 times. The ATRA authorized the QI program through December 31, 2013, and appropriated \$485 million for the second through the fourth quarters of FY 2013 and \$300 million for the first quarter of FY2014.

President's Proposal

The President's budget would extend QI authorization through December 31, 2014. This proposal would authorize an additional 12 months of funding. **This proposal was included in the President's FY2013 Budget.**

Table 2. President's FY2014 Budget—Legislative Proposals and Estimated Costs/Savings for Medicare

(dollars in millions)

Legislative Proposals	New (N), Modified (M), or Repeated (R) from the President's FY2013 Budget	HHS Cost/Savings Estimates		
		FY2014	FY2014- FY2018	FY2014- FY2023
Medicare Part A				
Reduce Medicare Coverage of Bad Debt	R	-\$200	-\$8,360	-\$25,490
Better Align Graduate Medical Education Payments with Patient Care Costs	R	-780	-4,710	-10,980
Reduce Critical Access Hospital Reimbursements to 100% of Patient Care Costs	R	-90	-570	-1,430
Prohibit Critical Access Hospital Designation for Facilities That are Less Than 10 Miles from the Nearest Hospital	R	-40	-280	-690
Adjust Payment Updates for Certain Post-Acute Care Providers	R	-830	-16,540	-79,040
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	R	-190	-1,140	-2,520
Equalize Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	R	-140	-850	-1,950
Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions	R	-	-500	-2,210
Implement Bundled Payment for Post-Acute Care Providers	N	-	-290	-8,160
Clarify the Medicare DSH Statute	N	-	-	-
Medicare Part B				
Reduce Overpayment of Part B Drugs	N	-220	-1,840	-4,480
Modernize Payments for Clinical Laboratory Services	N	-	-1,080	-9,460
Exclude Certain Services from the In-Office Ancillary Services Exception	N	-	-2,140	-6,050
Modify Part B Deductible for New Beneficiaries	R	-	-110	-3,320
Introduce Home Health Copayments for New Beneficiaries	R	-	-60	-730
Introduce Part B Premium Surcharge for New Beneficiaries Purchasing Near First Dollar Medigap Coverage	R	-	-250	-2,910
Medicare Parts B and D				
Increase Income-Related Premiums Under Parts B and D	R	-	-6,000	-50,000

Legislative Proposals	New (N), Modified (M), or Repeated (R) from the President's FY2013 Budget	HHS Cost/Savings Estimates		
		FY2014	FY2014- FY2018	FY2014- FY2023
Medicare Advantage				
Increase the Minimum Medicare Advantage Coding Intensity Adjustment	N	-	-3,910	-15,340
Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids	N	-	-1,380	-4,050
Medicare Part D				
Align Medicare Drug Payments with Medicaid Policies for Low-Income Beneficiaries	R	-3,140	-40,290	-123,170
Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap	N	-	-1,580	-11,210
Encourage the Use of Generic Drugs by Low Income Beneficiaries	N	-350	-2,600	-6,730
Ensure Retroactive Part D Coverage of Newly-Eligible Low Income Beneficiaries	N	-	-	-
Administrative Proposals				
Strengthen IPAB to Reduce Long-Term Care Drivers of Medicare Cost Growth	R	-	-	-4,100
Establish an Integrated Appeals Process for Medicare-Medicaid Enrollees	N	-	-	-
Other				
Expand Medicare Data Sharing with Qualified Entities	N	-	-	-
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics (Medicare Impact)	R	-580	-3,410	-8,570
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicare Impact)	R	-	-590	-3,090
Extend the Qualified Individuals (QI) Program	R	405	590	590
Interactions (adjusts for savings realized through IPAB and other interactions)		-	100	14,470
Changes in Outlays from Legislative Proposals		-6,155	-97,790	-370,620
Savings from Program Integrity Proposals	R	-	-120	-400
Total Proposals Impacting Medicare		-\$6,155	-\$97,910	-\$371,020

Source: Table created by CRS based on data in the Department of Health and Human Services, *Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans*, <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>.

Notes: Totals may not add due to rounding. Totals differ from those in **Table I** because the savings in **Table I** include the savings for the legislative proposals for program management, which are discussed in the "Program Management Legislative Proposals" section.

DSH: Disproportionate Share Hospital

IPAB: Independent Payment Advisory Board

HHS: Health and Human Services

Medicaid Legislative Proposals

Medicaid Payments

Rebase Future DSH 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.²⁹ 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 CPI-U. In FY2012, federal Medicaid DSH allotments to states totaled \$11.3 billion. The ACA requires the Secretary to make aggregate reductions in Medicaid DSH allotments for each year from FY2014 to FY2020. The MCTRJCA and ATRA applied the FY2020 Medicaid DSH reduction to FY2021 and FY2022. Under current law, in FY2023, states' DSH allotments will rebound to their pre-ACA reduced levels with annual inflation adjustments for FY2014 through FY2023.

President's Proposal

The President's budget proposes to "rebase" the Medicaid DSH allotments for FY2023 and subsequent years by calculating the Medicaid DSH allotments for these years based on the ACA reduced levels. The FY2023 Medicaid DSH allotments would be each state's FY2022 allotment increased by the percentage change in CPI-U, and the allotments for subsequent years would be the previous year's allotment increased by the percentage change in CPI-U. **This proposal was included in the President's FY2013 Budget.**

Begin ACA DSH Reductions, One Year Later, in FY2015

Current Law

As mentioned above, the ACA requires the Secretary to make aggregate reductions in Medicaid DSH allotments for each year from FY2014 to FY2020. Specifically, these reductions equal to \$0.5 billion in FY2014, \$0.6 billion in FY2015, \$0.6 billion in FY2016, \$1.8 billion in FY2017, \$5.0 billion in FY2018, \$5.6 billion in FY2019, and \$4.0 billion in FY2020. The MCTRJCA and ATRA apply the \$4.0 billion reduction from FY2020 to FY2021 and FY2022.

President's Proposal

The President's budget proposes to delay the Medicaid DSH reductions for one year (i.e., the Medicaid DSH reductions will begin in FY2015) and apply the reduction of \$0.5 billion currently

²⁹ For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by (name redacted).

slated for FY2014 over the years FY2016 and FY2017. **This proposal was *not* included in the President's FY2013 Budget.**

Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates

Current Law

States are generally 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 (UPLs) apply under Medicaid include hospitals and nursing homes; federal regulations specify that states cannot pay more in the aggregate for inpatient hospital services or long-term care services than the amount that would be paid for the services under the Medicare principles of reimbursement. No UPL currently applies to 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. MMA 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. The first round of the competitive bidding program began in July 2008 in 10 areas, but was halted due to implementation concerns. A new first round of competition began in October 2009, and contracts and payments for the competitive bidding areas went into effect in January 2011. Implementation of the second round of competition started in 2011 in 91 additional areas, and CMS expects that payments and contracts under the second round will start in July 2013. The Secretary is required to extend the competitive acquisition program, or use information from the program to adjust fee schedule rates in remaining areas by 2016.

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 FY2013 Budget.**

Clarify the Medicaid Definition of Brand Drugs

Current Law

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 original new drug application but for which generic equivalents now are available); and (2) all other, non-innovator, multiple source drugs. Rebates for the first category of drugs (i.e., drugs still under patent or those once covered by patents) have two components: a basic rebate and an additional rebate. Medicaid's basic rebate is determined by the larger of either a comparison of a drug's quarterly Average Manufacturer Price (AMP) to the best price for the same period, or a flat percentage (23.1%) of the drug's

quarterly AMP. Drug manufacturers owe an additional rebate when their unit prices for individual products increase faster than inflation. For innovator multiple-source and all other non-innovator multiple source drugs, manufacturers' Medicaid rebates are 13% of AMP.

Manufacturers sometimes market their patented products, or versions of their patented products, as over-the-counter (OTC) products, before their patents expire. When AMP for OTC sales are combined with AMP for patented product sales, it can reduce manufacturers' Medicaid rebate obligations for those products.

President's Proposal

The President's budget proposes to clarify that certain drugs still be considered brand drugs (i.e., innovator multiple source products) even though manufacturers have converted them to OTC products. The proposal also would remove the "original" from the definition of single source and innovator multiple source drugs. Moreover, this proposal would close other technical loopholes that might have enabled drug manufacturers to pay lower Medicaid drug rebates than otherwise would be required under Medicaid law. **This proposal was *not* included in the President's FY2013 Budget.**

Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits

Current Law

The ACA refined the definition of Medicaid multiple-source, generic, drugs.³⁰ The ACA increased the number of drugs considered by the FDA as therapeutically and pharmacologically equivalent products from two to three which requires the Secretary to establish federal upper limits (FULs) for those products. Medicaid prescription drug FULs are used to limit reimbursement for certain multiple source drugs. Medicaid drug FULs are calculated based on the weighted average price of all drugs, brand, authorized generic, and generic drugs, in each product code.³¹

President's Proposal

The President's budget would specify that the amounts paid for brand and authorized generics would be excluded from the Medicaid prescription drug FUL calculations. **This proposal was *not* included in the President's FY2013 Budget.**

³⁰ ACA Sec. 2503, Providing Adequate Reimbursement to Pharmacies. For more information see ACA sections 2501-2503 made a number of changes to the Medicaid drug rebate program by amending applicable provisions in the Social Security Act. For more information on the Medicaid drug rebate changes, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, page 32.

³¹ There is one Healthcare Common Procedure Coding System code for each single source drug (brand name drug), but there can be several or many drugs included in HCPCS codes for multiple source products. The FUL for multiple source products includes sales for each drug and manufacturer weighted by the volume of each drug sold.

Exclude Authorized Generics from Medicaid Brand Name Rebate Calculations

Current Law

Outpatient prescription drugs are an optional Medicaid benefit, but all states cover prescription drugs for most beneficiary groups. Medicaid law requires prescription drug manufacturers who wish to sell their products to Medicaid agencies to enter into rebate agreements with the Secretary on behalf of states. Under these agreements, drug manufacturers pay a rebate to state Medicaid agencies for drugs purchased for Medicaid beneficiaries.

Authorized generics are drugs that the original patent holder has licensed to a generic drug manufacturer to sell at a negotiated, reduced price.³² It is argued that authorized generics raise prices for consumers and reduce incentives for generic manufacturers to challenge single source drug patents. Including authorized generic sales with brand product 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).³³

President's Proposal

The President's budget would change the calculation of Medicaid rebates for single source (i.e., brand name) products to exclude sales of authorized generic drugs. By removing authorized generic sales from the single source product's AMP calculation, the AMP would be higher thus increasing the rebate owed by manufacturers on brand name drugs. **This proposal was *not* included in the President's FY2013 Budget.**

Correct the ACA Medicaid Rebate Formula for New Drug Formulations

Current Law

Under previous law, 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. For example, manufacturers have developed extended-release formulations of existing products which, because they were considered new products under previous Medicaid drug rebate rules, were given new base period AMPs. The new base period AMPs for line-extension products would be higher than the original product's AMP. For line-extension products, manufacturers are less likely to owe additional rebates since the product's AMP would not have had time to have risen faster than the rate of inflation. ACA included a provision that required manufacturers to pay Medicaid rebates (both

³² See Code of Federal Regulations (CFR) 42 CFR §447.506, an authorized generic drug means any drug sold, licensed, or marketed under an New Drug Application approved by the FDA under section 505(c) of the Federal Food Drug and Cosmetics Act; and marketed, sold, or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repackaging the listed drug for use in institutions) than the brand drug.

³³ Medicaid collects an additional rebate from drug manufacturers when their products prices rise faster than the rate of inflation. The additional rebates also would increase if sales of authorized generics are excluded from the calculation of brand-name drug AMPs.

basic and additional rebates) on line-extension products as if they were the original product on which the line extension was based.³⁴

President's Proposal

The President's budget would make a technical correction to the ACA provision to amend the statute and correct rebate formula for line-extension drugs. **This proposal was *not* included in the President's FY2013 Budget.**

Medicaid Benefits

Expand State Flexibility to Provide Benchmark Benefit Packages

Current Law

As an alternative to traditional Medicaid benefits, states may enroll certain Medicaid beneficiaries into benchmark benefit plans that include four choices: (1) the standard Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program, (2) a plan offered to state employees, (3) the largest commercial health maintenance organization in the state, and (4) other coverage appropriate to the targeted population, subject to approval of the Secretary. Additionally, states may opt for benchmark-equivalent coverage, which must have the same actuarial value as one of the benchmark plans and must also include certain services (e.g., inpatient care, physician services, prescribed drugs, among others). The ACA established a new Medicaid eligibility group for non-elderly, non-pregnant adults with income up to 133% of FPL beginning in 2014, or sooner at state option. Such individuals will be enrolled in benchmark plans rather than traditional Medicaid (with some exceptions for subgroups with special medical needs).

President's Proposal

The President's budget would allow benchmark-equivalent coverage for non-elderly, non-disabled adults with income that exceeds 133% of FPL. **This proposal was included in the President's FY2013 Budget.**

Medicaid Coverage

Extend the Transitional Medical Assistance (TMA) Program through CY 2014

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to (1) increased child or spousal support

³⁴ ACA Sec. 2501(d), Additional Rebate For New Formulations of Existing Drugs. For more information, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, page 37.

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 six, 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 who 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 ARRA. Under the ARRA option, states may choose to provide work-related TMA for a full 12-month period rather than two six-month periods. Congress has acted on numerous occasions to extend these expanded TMA requirements (which are outlined in Section 1925 of the Social Security Act) beyond their original sunset date of September 30, 1998. Most recently, the ATRA extended the authorization and funding of expanded TMA requirements through December 31, 2013.

President's Proposal

The President's budget would extend authorization and funding of expanded TMA requirements through December 31, 2014, and would adopt the Medicaid and CHIP Payment and Access Commission recommendation to permit states that adopt the ACA Medicaid expansion to opt out of TMA. **This proposal is a modification of a legislative proposal from the President's FY2013 Budget.**

Establish Hold-Harmless for Federal Poverty Guidelines

Current Law

The HHS poverty guidelines (also referred to as the FPL) are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty. The HHS poverty guidelines are published annually in the Federal Register (usually in January) and are used for administrative purposes such as determining financial eligibility for certain federal programs, including Medicaid. Federal law requires the Secretary to update the poverty guidelines at least annually by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the CPI-U as calculated by the Bureau of Labor Statistics. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The 2013 poverty guidelines reflect actual price changes between calendar years 2011 and 2012.

President's Proposal

The President's budget would establish a permanent hold harmless provision to ensure that the HHS poverty guidelines are only adjusted when there is an increase in the CPI-U. The provision would impact social programs that rely on the poverty guidelines for administrative purposes (such as Medicaid, Supplemental Nutrition Assistance Program, Women, Infants and Children, etc.). **This proposal was included in the President's FY2013 Budget.**

Other

Extend Supplemental Security Income Time Limits for Qualified Refugees

Current Law

SSI, which provides means-tested cash benefits to aged, blind, and disabled persons, is generally only available to U.S. citizens and in some limited cases, certain legal permanent residents of the United States. However, certain classes of refugees; asylees; and other humanitarian immigrants, such as Cuban and Haitian entrants or Iraqi and Afghan special immigrants may receive SSI benefits for up to seven years after entering the United States or attaining refugee status. If, after the conclusion of this seven-year period, a refugee, asylee, or humanitarian immigrant has not attained citizenship or permanent resident status, then he or she is ineligible for any future SSI benefit payments.

President's Proposal

The President's budget proposes to extend the current seven-year period of SSI eligibility for refugees, asylees, and humanitarian immigrants to nine years through the end of FY2015. At the end of FY2015, the eligibility period for refugees, asylees, and humanitarian immigrants would return to seven years. **This proposal was included in the President's FY2013 Budget.**

Eliminate Medicaid Recoupment of Birthing Costs from Child Support

Current Law

Currently, if a custodial parent has no private medical coverage at the time of her child's birth, the father can be held financially responsible for payment of the birth costs. Federal law (Section 1902(a)(25)(F) of the Social Security Act) permits states to use the Child Support Enforcement program to collect money from noncustodial fathers to reimburse the Medicaid agency for birth costs of children receiving Medicaid benefits.

President's Proposal

The President's budget proposes to prohibit the use of child support to repay Medicaid costs associated with giving birth—a practice retained by several states. **This proposal was *not* included in the President's FY2013 Budget.**

Table 3. President's FY2014 Budget—Legislative Proposals and Estimated Costs/Savings for Medicaid

(dollars in millions)

Legislative Proposals	New (N), Modified (M), or Repeated (R) from the President's FY2013 Budget	HHS Cost/Savings Estimates		
		FY2014	FY2014- FY2018	FY2014- FY2023
Medicaid Payments				
Rebase Future DSH Allotments	R	-	-	-\$3,630
Begin ACA DSH Reductions, One Year Later, in FY2015 ^a	N	360	-	-
Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates	R	-250	-1,750	-4,483
Clarify the Medicaid Definition of Brand Drugs	N	-21	-116	-256
Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits	N	-90	-740	-1,740
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations	N	-30	-160	-355
Correct the ACA Medicaid Rebate Formula for New Drug Formulations	N	-270	-2700	-6,450
Medicaid Benefits				
Expand State Flexibility to Provide Benchmark Benefit Packages	R	-	-	-
Medicaid Coverage				
Extend the Transitional Medical Assistance (TMA) Program Through CY 2014	M	480	1,055	1,055
Integrate Appeals Process for Medicare-Medicaid Enrollees ^b	N	-	-	-
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries ^b	N	-	-	-
Establish Hold-Harmless for Federal Poverty Guidelines	R	-	-	-
Other				
Extend Supplemental Security Income Time Limits for Qualified Refugees ^c	R	11	24	24
Eliminate Medicaid Recoupment of Birthing Costs from Child Support ^d	N	-	-	-
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicaid Impact) ^b	R	10	-50	-190
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics (Medicaid Impact) ^b	R	-170	-1,040	-2,430
Total Changes in Outlays from Legislative Proposals		30	-5,477	-18,455
Savings from Program Integrity Proposals ^e		-156	-1,478	-3,691
Total Proposals Impacting Medicaid		-\$126	-\$6,955	-\$22,146

Source: Table created by CRS based on data in the Department of Health and Human Services, *Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans*, <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>.

Notes: Totals may not add due to rounding.

ACA: Affordable Care Act

DSH: Disproportionate Share Hospital

HHS: Health and Human Services

- a. CMS Office of the Actuary projects that postponing the DSH reductions will increase outlays by \$360 million in FY 2014. This proposal is budget neutral over 5- and 10-year windows because the scheduled cuts are redistributed to FY 2016 and FY 2017.
- b. These proposals impact both the Medicare and Medicaid programs. See the "Medicare Legislative Proposals" section for descriptions of these legislative proposals.
- c. This proposal is included in the Social Security Administration's FY2014 Budget Request.
- d. This proposal is included in the Administration for Children and Families' FY2014 Budget Request.
- e. See the "Program Integrity Legislative Proposals" section for the descriptions of the legislative proposals impacting Medicaid.

Program Integrity Legislative Proposals

Medicare

Require Prepayment Review or Prior Authorization for Power Mobility Devices

Current Law

Under current law, Medicare covers DME, including power wheelchairs and other power mobility devices (PMDs), when it is determined to be medically necessary.³⁵ There is a history of fraud and abuse associated with DME and PMDs. PMDs are expensive items that are sometimes prescribed for beneficiaries when not medically necessary, or when a less expensive device, such as a cane or walker, would be more advisable. With an estimated 3-10% of Medicare spending lost to fraud, there has been increasing attention focused on stopping inappropriate or fraudulent Medicare claims.³⁶ The ACA added a number of new program integrity tools, including a requirement that Medicare beneficiaries have a face-to-face examination with providers before DME may be prescribed (PMDs already required a face-to-face examination by the provider). In addition, CMS is focusing enhanced scrutiny on areas at high-risk for improper payments and fraud, which include areas of higher expenditure and utilization of services. Recently, CMS announced a demonstration that would require that PMDs in seven states receive prior authorization, before beneficiaries receive equipment.³⁷ Medicare's FY2010 expenditures for

³⁵ For more information on Medicare coverage and payment for durable medical equipment, see CRS Report R41211, *Medicare Durable Medical Equipment: The Competitive Bidding Program*, by (name redacted).

³⁶ For more information on Medicare fraud, see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by (name redacted).

³⁷ The seven states included in CMS's prior authorization demonstration for power mobility devices are California, (continued...)

PMDs in these states were 43% (\$261 million) of the \$606 million of Medicare's total PMD expenditures. The demonstration originally was to commence January 1, 2012 but was delayed until September 1, 2012. CMS revised the original scope, and the demonstration is slated to end August 31, 2015.³⁸

President's Proposal

The President's budget proposal would continue the Medicare PMD prior-authorization demonstration. **This proposal was included in the President's FY2013 budget proposal.**

Allow Civil Monetary Penalties 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. CMS uses provider/supplier enrollment records to monitor provider status. Current provider records help to ensure that providers who could pose a higher risk of fraudulent activity receive greater scrutiny when applying and afterwards in submitting reimbursement claims.

President's Proposal

The President's budget would authorize the Secretary to impose civil penalties when providers and suppliers fail to update enrollment records on a timely basis. **This proposal was included in the President's FY2013 budget proposal.**

Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High Risk Items and Services

Current Law

Claims processing systems currently do not contain data that could be used to determine if a patient actually saw a practitioner or whether services billed on a claim were determined to be medically necessary. This information could be useful in determining whether a federal health care claim is valid prior to payment. In order to validate whether high-risk services were determined to be medically necessary and whether practitioners ordered those services, additional information would need to be required with the reimbursement claim.

(...continued)

Illinois, Michigan, New York, North Carolina, Florida, and Texas. Medicare enrollment in these states represented approximately 39% of enrollment in original Medicare in FY2010.

³⁸ https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/PADemo.html?redirect=/CERT/03_PADemo.asp.

Many providers and health systems are implementing electronic health records (EHR) systems. Provisions in ARRA and the ACA provided financial incentives to providers to invest in EHR.³⁹ Many EHR systems either are linked or have the capability to interact with clinical decision support systems and electronic claims processing. Electronic patient records may contain information on what services practitioners ordered, whereas claims processing systems only have information necessary to request reimbursement from payers, such as Medicare, Medicaid, or CHIP. As these EHR and claims processing systems become the standard of practice, it may be possible for program integrity systems to routinely validate that practitioners ordered specific treatments, tests, or other procedures at high risk for fraud.

Current law does not specifically require the Secretary to develop or implement a system for validating practitioner orders for high-risk services.

President's Proposal

The President's budget would implement an electronic Medicare claims ordering system that could validate whether practitioners determined high-risk services were medically necessary and whether patients received those services. **This proposal was included in the President's FY2013 budget proposal.**

Increase Scrutiny of Providers Using Higher-Risk Banking Arrangements to Receive Medicare Payments

Current Law

There is no restriction or increased oversight when providers employ banking arrangements, such as sweep accounts and wire-transfers to off-shore accounts that might be at higher risk of fraudulent activities. In some cases, Medicare has been unable to recover improper payments because providers quickly transferred Medicare's payments to other jurisdictions. These providers were able to shield large Medicare payments from recovery actions because the improper payments were deposited into accounts where federal prosecutors had limited authority.

President's Proposal

The President's budget proposes to authorize the Secretary to require Medicare providers and suppliers to report the use of accounts that immediately transfer funds to sweep accounts in other jurisdictions where it might be difficult for Medicare to recover improper payments from these providers. **This proposal was included in the President's FY2013 budget proposal.**

³⁹ For more information on Electronic Health Records, see CRS Report RL32858, *Health Information Technology: Promoting Electronic Connectivity in Healthcare*, by (name redacted).

Require Prior Authorization for Advanced Imaging

Current Law

Over the last decade, the growth of imaging services provided under the Medicare program has exceeded those of most other Part B services. From 2000 through 2006, the Government Accountability Office (GAO) has found that “spending on advanced imaging, such as CT scans, MRIs, and nuclear medicine, rose substantially faster than other imaging services such as ultrasound, X-ray, and other standard imaging.”⁴⁰ More recently, another GAO study 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.”⁴¹ 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 would adopt prior authorization for the most expensive imaging services. **This proposal was included in the President's FY2013 budget proposal.**

Medicaid

Expand Medicaid Fraud Control Unit (MFCU) 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.⁴² MFCUs also have authority to review nursing home residents' neglect or abuse complaints 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 non-institutional settings. MFCUs are responsible for investigating fraud in administration of the state Medicaid program itself and in collecting overpayments they identify in the course of their work. MFCUs have authority, with the Inspector General's approval, to investigate fraud in other federally-funded health care programs, such as Medicare or CHIP, that are primarily related to Medicaid. MFCUs are prohibited from investigating beneficiary fraud, unless it is part of a conspiracy with a provider. In 2011, the

⁴⁰ U.S. Government Accountability Office, *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices*, GAO-08-452, June 13, 2008, <http://www.gao.gov/products/GAO-08-452>.

⁴¹ U.S. Government Accountability Office, *Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions*, GAO-12-966, September 28, 2012, <http://www.gao.gov/products/GAO-12-966>.

⁴² MFCUs generally are located in state attorney general offices, but the MFCU for six states (CT, GA, IL, IA, TN and WV) and DC is located in other non-Medicaid state agencies. North Dakota has a waiver from federal requirements so it does not have a MFCU.

Office of the Inspector General (OIG) issued proposed regulations that would permit MFCUs to receive federal financial participation (FFP, i.e., federal Medicaid matching funds) for “data mining,” which is computer screening of Medicaid claims to help identify potentially fraudulent activity.⁴³ MFCUs are funded partially through a grant from the HHS OIG (75%) and partially with matching state funds (25%).

President's Proposal

The President's budget would expand the range of care settings where MFCUs would have authority to receive FFP for investigation of patient complaints. These settings might include home- and community-based services and providers. **This proposal was *not* included in the President's FY2013 budget proposal.**

Strengthen Medicaid Third-Party Liability

Current Law

Under third-party liability (TPL) rules, Medicaid is the payer of last resort. If another insurer or program (e.g., private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other state and federal programs) has the responsibility to pay for medical costs incurred by Medicaid-eligible individuals, generally that entity is required to pay all or part of the bill before Medicaid makes any payment. Third parties are not responsible for reimbursing Medicaid for services not covered under Medicaid state plans. States are required to determine if third parties exist, and to ensure that providers bill the third-party first, before billing Medicaid. Whenever states pay Medicaid claims and then discover that a third party exists, they are required to recover overpayments from the third parties. The DRA strengthens states' TPL authority to identify and recover Medicaid payments for which third parties were liable by clarifying what entities are considered third parties and requiring states to pass laws that require insurers to comply with Medicaid TPL rules.

President's Proposal

The President's budget would expand Medicaid's TPL authority by allowing states to (1) delay payment of costs for prenatal and preventive pediatric costs/expenditures when third parties are responsible; (2) collect medical child support from non-custodial parents when these parents have health insurance; and (3) recover costs from beneficiary liability settlements. **This proposal was included in the President's FY2013 budget proposal.**

⁴³ Department of Health and Human Services, “State Medicaid Fraud Control Units; Data Mining,” 76 *Federal Register* 14637, March 17, 2011.

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid

Current Law

Medicaid statute gives states broad authority to implement a variety of prescription drug monitoring activities; not all states have adopted such activities. A number of 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 from designated providers only (i.e., one pharmacy or a specific primary care provider). Other states have linked Medicaid data with statewide prescription drug monitoring programs. 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 proposal 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 would have discretion to tailor their programs, for example, by choosing one or more drug classes subject to overuse or abuse. States would be required to develop or review and update their high-utilization remediation plan to reduce excessive utilization and preventable abuse episodes and improve Medicaid integrity, but without reducing beneficiary quality of care. **This proposal was included in the President's FY2013 budget proposal.**

Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States

Current Law

Drug manufacturers that want to sell their products to Medicaid programs must agree to pay rebates for drugs provided to Medicaid beneficiaries. Under the terms of the Medicaid drug rebate program, manufacturers must make their entire product line available, and Medicaid must cover all of a manufacturer's products, except certain drugs or drug classes identified in law on an “excluded drug list.”⁴⁴ Rebates paid by manufacturers to Medicaid are calculated based on each manufacturer's AMP for a drug. AMP is defined in law.⁴⁵ Studies and legal settlements between drug manufacturers and state Medicaid programs have shown some irregularities in how manufacturers interpreted CMS guidance on what sales transactions should be included in AMP. States are permitted to exclude coverage of drugs on the excluded drug list, but they also may cover these drugs. Manufacturers sometimes include sales transactions for excluded drugs in their calculation of AMP. By including these excluded drug sales in the calculation of AMP, rebates owed to states can be reduced.

⁴⁴ See Social Security Act Sec. 1927(d)(2).

⁴⁵ CMS published a Notice of Proposed Rule Making with guidance for manufacturers and other stakeholders on calculation of average manufacturer price and other Medicaid drug rebate issues. For more information, see Centers for Medicare & Medicaid, “Medicaid Program; Covered Outpatient Drugs,” 77 *Federal Register* 5318, February 2, 2012.

President's Proposal

The President's budget proposal would require manufacturers that improperly reported drugs (that Medicaid does not cover) in their AMP calculations to fully compensate states for the drug rebates they would have received if the manufacturer had properly excluded drugs not covered by Medicaid. **This proposal was included in the President's FY2013 budget proposal.**

Enforce Manufacturer Compliance with Drug Rebate Requirements

Current Law

CMS has authority to survey drug manufacturers, and HHS OIG has 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. CMS conducts automated data checks on the drug prices reported by manufacturers and notifies manufacturers when it identifies discrepancies or errors. There is substantial variation in the methodologies and assumptions drug manufacturers follow in reporting drug price data to CMS. Even though drug manufacturers' methodologies and assumptions for reporting drug prices can have a great impact on rebates, CMS does not generally verify that manufacturers' documentation supports their prices and does not routinely check that their price determinations are consistent with the Medicaid statute, regulations, or the rebate agreement.⁴⁶ Studies have found and False Claims Act settlements have shown irregularities in manufacturers' drug price reporting. The ACA made a number of changes to Medicaid prescription drug pricing policies, including provisions to create more uniform manufacturer drug reporting standards.⁴⁷

President's Proposal

The President's budget would require, to the extent they are cost effective, that regular audits and surveys of drug manufacturers be conducted to evaluate manufacturers' compliance with drug rebate agreements, the Medicaid statute, and regulations. **This proposal was included in the President's FY2013 budget proposal.**

Require Drugs Be Electronically Listed with FDA to Receive Medicaid Coverage

Current Law

Under federal law and regulation, outpatient prescription drugs may be covered by Medicaid if the drugs were approved for safety and effectiveness by the FDA under the Federal Food Drug and Cosmetics Act (P.L. 75-717). The FDA approves drugs when a manufacturer obtains a New

⁴⁶ For example, see Government Accountability Office, *Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States*, GAO-05-102, February 2005.

⁴⁷ CMS published a Notice of Proposed Rule Making that proposed changes and clarified Medicaid drug price definitions, such as average manufacturer price. See Centers for Medicare & Medicaid, "Medicaid Program; Covered Outpatient Drugs," 77 *Federal Register* 5318, February 2, 2012.

Drug Approval, generally for sole source brand name drugs, or where a manufacturer obtains an ANDA, generally for multiple source, generic drugs. Federal regulations limit Medicaid reimbursement for outpatient drugs 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 could be used both on-label and off-label.⁴⁸ Even though current law requires drug manufacturers to list their products with the FDA, not all drugs on the market are properly listed. CMS published a Notice of Proposed Rule Making that proposed a number of regulatory changes that were authorized by the ACA.⁴⁹

President's Proposal

The President's budget would require that drug manufacturers list their products electronically with the FDA in order to be covered and reimbursed by Medicaid. This proposal also would align Medicaid drug coverage requirements with Medicare's requirements. **This proposal was included in the President's FY2013 budget proposal.**

Increase Penalties for Fraudulent Noncompliance on Rebate Agreements

Current Law

Drug manufacturers that want to sell products to state Medicaid programs must agree to offer rebates to states, which are shared with the federal government. As part of the Medicaid rebate agreement, drug manufacturers are required to report accurate drug price information to CMS so it can compute or verify drug rebates. CMS guidance permits manufacturers to make "reasonable assumptions" consistent with the "intent" of the law, regulations, and rebate agreement. Thus, manufacturers determine which sales transactions to include when reporting prices to CMS. Provisions in the ACA amended the Medicaid drug rebate statute, and CMS published a proposal that would implement ACA's Medicaid drug rebate changes. Individuals (including an organization, agency, or other entity) who knowingly make or cause to be made false statements, omissions, or misrepresentations of material fact in applications, bids, or contracts could be subject to fines, program exclusions, and/or criminal penalties. However, the civil monetary and criminal provisions applicable to all federal health care programs are not specifically designed to address Medicaid drug rebate reporting violations.

President's Proposal

The President's budget proposed to increase penalties on drug manufacturers that knowingly report false information under Medicaid drug rebate pricing agreements that are used to calculate Medicaid rebates. **This proposal was included in the President's FY2013 budget proposal.**

⁴⁸ Social Security Act (SSA) section 1861(t)(2)(B)(ii)(I) as amended by Section 6001(f)(1) of the Deficit Reduction Act of 2005, P.L. 109-171, recognizes three compendia: (1) American Medical Association Drug Evaluations; (2) United States Pharmacopoeia-Drug Information or its successor publication; and (3) American Hospital Formulary Service-Drug Information (AHFS-DI).

⁴⁹ CMS published a Notice of Proposed Rule Making that proposed changes and clarified Medicaid drug program definitions, including the requirements that covered drugs be electronically listed with the FDA. See Centers for Medicare & Medicaid, "Medicaid Program; Covered Outpatient Drugs," 77 *Federal Register* 5318, February 2, 2012.

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

Current Law

Medicaid and CHIP are jointly funded by the federal government and the states. Federal reimbursement for the cost of Medicaid services is provided on an open-ended basis to states that meet federal program requirements. The federal government's share of most Medicaid expenditures is called the federal medical assistance percentage (FMAP) rate.⁵⁰ However, exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, services, and administration. Federal matching funds for CHIP are provided to states according to an enhanced FMAP (E-FMAP) rate, which is calculated by reducing the state share under the regular FMAP rate by 30%. The E-FMAP is provided for both services and administration under CHIP, but federal CHIP matching funds are capped on a state-by-state basis according to annual allotments.⁵¹ In general, federal regulations prohibit states from using other federal sources to fund the state share of Medicaid, unless authorized by law.

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 FY2013 budget proposal.**

Consolidate Redundant Error Rate Measurement Programs

Current Law

The Improper Payments Information Act of 2002 (IPIA, P.L. 107-300) required federal agencies to annually review 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 (PERM), which estimates improper Medicaid and CHIP payments. In addition to PERM, federal Medicaid law requires states to assess Medicaid eligibility and quality control (MEQC).⁵² MEQC requires each state to calculate and report erroneous Medicaid payment and eligibility determination rates. States have discretion to develop and implement their own MEQC methodologies. Under CMS PERM regulations, states now have the option to use PERM to fulfill the MEQC requirement.⁵³

⁵⁰ For more information about FMAP rates, see CRS Report R42941, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014*, by (name redacted) and (name redacted).

⁵¹ For more information about CHIP, see CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by (name redacted) and (name redacted).

⁵² See Social Security Act Sec. 1903(u)(2).

⁵³ Centers for Medicare & Medicaid Services, "Medicaid Program and Children's Health Insurance Program (CHIP); Revisions to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs," *75 Federal Register* 154, August 11, 2010.

President's Proposal

The President's budget would authorize the Secretary to create a streamlined audit program that consolidated the MEQC and PERM programs. **This proposal was included in the President's FY2013 budget proposal.**

Medicare and Medicaid

Retain a Portion of Recovery Audit Contractors (RAC) Recoveries to Implement Actions That Prevent Fraud and Abuse

Current Law

RACs receive a percentage of any improper payments they recover. Congress initially authorized RACs as limited demonstrations for Medicare Parts A and B fee-for-service, but expanded the program nationally. Then, under the ACA, Congress authorized further RAC expansion to Medicare Parts C and D and Medicaid. Total RAC fee-for-service corrections for FY2010 through the first quarter of FY2013, including overpayment collections and underpayments returned, were \$4.2 billion, of which \$3.9 billion were for overpayment collections and \$302.6 million were returned underpayments. Under current law, RAC recoupments, net of the percentage payments to contractors and other administrative expenses are returned to the Medicare Trust Fund.⁵⁴

President's Proposal

The President's budget would authorize CMS to retain a portion of RAC recoveries from Medicare and Medicaid to fund corrective actions, such as new processing edits and provider education and training, to prevent future improper payments. **This proposal was included in the President's FY2013 budget proposal.**

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

Current Law

HHS OIG has authority to exclude health care providers (individuals and entities) from participation in federal health care programs. HHS OIG exclusion authority is mandatory in some circumstances and optional in others. The ACA extended HHS OIG authority to include individuals or entities that make false statements or misrepresentations on federal health care program enrollment applications, including explicit applicability to MA plans, PDPs, and these organization's providers and suppliers.

⁵⁴ For more information, see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by (name redacted).

President's Proposal

The President's budget would expand HHS OIG authority to exclude individuals and entities from federal health programs if they are affiliated with sanctioned entities. The proposal would eliminate a 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's exclusion authority also would be extended to entities affiliated with sanctioned entities. **This proposal was included in the President's FY2013 budget proposal.**

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/supplier billing privileges could be used to submit fraudulent claims to Medicare, Medicaid, or the CHIP 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 FY2013 budget proposal.**

Improve Prisoner Database to Determine Eligibility for Improper Payments

Current Law

Medicare and Medicaid limit or preclude federal coverage of health services for individuals who are in custody or incarcerated. In Medicare, payment for medical services delivered to beneficiaries who are in custody (for example, on parole, probation, bail, or incarcerated) can only be made if certain conditions are met.⁵⁵ In Medicaid, in general, no federal financial participation (i.e., federal Medicaid matching dollars) are available for medical services delivered to inmates of public institutions. Inmates of non-federal correctional facilities are wards of the state. Thus, states are responsible for their care, not the federal government. Specifically, while serving time for a criminal offense or confined involuntarily in state or federal prisons, jails, detention facilities or other penal facilities, no federal matching funds are available to pay for Medicaid services delivered to that inmate. However, the federal statute provides for an exception to the prohibition on federal matching funds when an inmate becomes an inpatient in a medical facility (e.g., hospital) and the inmate is otherwise eligible for Medicaid.

⁵⁵ See 42 CFR §411.4(b).

President's Proposal

The President's budget includes a multi-agency proposal increasing federal and state access to the Prisoner Update Processing System, which is the Social Security Administration's database containing federal, state, and local prisoner data. This proposal also expands the type of information prisons are required to report to SSA, such as release dates, so that programs responsible for providing federal or state benefits can prevent improper payments to or on behalf of incarcerated individuals. **This proposal was not included in the President's FY2013 budget proposal.**

Table 4. President's FY2014 Budget—Legislative Proposals and Estimated Savings for Program Integrity Activities

(dollars in millions)

Legislative Proposals	New (N), Modified (M), or Repeated (R) from the President's FY2013 Budget	HHS Cost/Savings Estimates		
		FY2014	FY2014- FY2018	FY2014- FY2023
Medicare				
Require Prepayment Review or Prior Authorization for Power Mobility Devices	R	-	-\$40	-\$90
Allow Civil Monetary Penalties for Providers and Suppliers Who Fail to Update Enrollment Records	R	-	-40	-90
Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High Risk Items and Services	R	-	-	-
Increase Scrutiny of Providers Using Higher-Risk Banking Arrangements to Receive Medicare Payments	R	-	-	-
Require Prior Authorization for Advanced Imaging	R	-	-	-
Medicaid				
Expand Medicaid Fraud Control Unit (MFCU) Review to Additional Care Settings	N	-5	-30	-73
Strengthen Medicaid Third-Party Liability	R	-100	-680	-1,690
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	R	-50	-720	-1,820
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States	R	-1	-8	-18
Enforce Manufacturer Compliance with Drug Rebate Requirements	R	-	-	-
Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage	R	-	-	-
Increase Penalties for Fraudulent Noncompliance on Rebate Agreements	R	-	-	-
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	R	-	-	-
Consolidate Redundant Error Rate Measurement Programs	R	-	-	-
Medicare and Medicaid				
Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse	R	-	-70	-250

Legislative Proposals	New (N), Modified (M), or Repeated (R) from the President's FY2013 Budget	HHS Cost/Savings Estimates		
		FY2014	FY2014- FY2018	FY2014- FY2023
Permit Exclusion From Federal Health Care Programs if Affiliated with Sanctioned Entities	R	-	-10	-60
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	R	-	-	-
Improve Prisoner Database to Determine Eligibility for Improper Payments	N	-	-	-
Total Changes in Outlays from Legislative Proposals Impacting Program Integrity		-156	-1,598	-4,091
Savings from Program Integrity Investments ^a		-387	-1,837	-7,362
Total Program Integrity Savings		-\$543	-\$3,435	-\$11,453

Source: Table created by CRS based on data in the Department of Health and Human Services, *Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans*, <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>.

Notes: Totals may not add due to rounding.

CHIP: State Children's Health Insurance Program

HHS: Health and Human Services

RAC: Recovery Audit Contractors

- a. Savings from Program Integrity Investments reflect combined savings from HCFAC investment (including both mandatory and discretionary spending) and savings from Social Security Disability Review investment. This includes non-PAYGO Scorecard savings from additional investments above savings already assumed in current law.

Private Health Insurance Legislative Proposals

Accelerate Issuance of State Innovation Waivers

Current Law

Under section 1332 of the ACA, a state may apply to the Secretaries of HHS and Treasury for waivers of certain ACA requirements with respect to health insurance coverage in that state for plan years beginning on or after January 1, 2017. A state may apply for a "state innovation waiver" for all or any of the following ACA requirements:

- Title I, subtitle D, Part I (relating to the establishment of qualified health plans);
- Title I, subtitle D, Part II (relating to consumer choice and insurance competition through health benefit exchanges),⁵⁶

⁵⁶ For more information about exchanges, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

- Section 1402 (relating to reduced cost sharing for individuals enrolling in qualified health plans);
- Section 36B of the Internal Revenue Code (relating to refundable tax credits for coverage under a qualified health plan offered through an exchange);⁵⁷
- 4980H of the Internal Revenue Code (relating to shared responsibility for employers regarding health coverage);⁵⁸
- And 5000A of the Internal Revenue Code (relating to the requirement to maintain minimum essential coverage).⁵⁹

The Secretaries have the authority to grant a request for one or more state innovation waivers if the Secretaries determine that the state has legislation in place that creates a system or plan that will provide health insurance coverage that is at least as comprehensive and affordable as coverage provided under the ACA; will provide that coverage to a comparable number of its residents as provisions of the ACA would provide; and will not increase the federal deficit.

President's Proposal

The President's budget would allow states to apply for state innovation waivers beginning in 2014, three years earlier than is currently permitted. **This proposal was included in the President's FY2013 budget proposal.**

Table 5. President's FY2014 Budget—Legislative Proposals and Estimated Costs/Savings for Private Health Insurance

(dollars in millions)

Legislative Proposals	New (N), Modified (M), or Repeated (R) from the President's FY2013 Budget	HHS Cost/Savings Estimates		
		FY2014	FY2014- FY2018	FY2014- FY2023
Accelerate Issuance of State Innovation Waivers	R	-	-	-

Source: Table created by CRS based on data in the Department of Health and Human Services, *Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans*, <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>.

HHS: Health and Human Services.

⁵⁷ For more information on the refundable tax credits offered through an exchange, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

⁵⁸ For more information on employer responsibilities under the ACA, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted).

⁵⁹ For more information on the requirement for individuals to maintain health insurance coverage, see CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*, by (name redacted) and (name redacted).

Program Management Legislative Proposals

Provide Mandatory Administrative Resources for Implementation

Current Law

CMS's Program Management account funds the majority of Medicare's administrative and oversight functions, and Program Management activities include both discretionary and mandatory appropriations. Discretionary Program Management includes the following five account categories: program operations, federal administration, survey and certification, research, and state high-risk pools. The largest Program Management expenditure category is program operations, which funds a range of contractor and information technology activities necessary to administer Medicare, Medicaid, CHIP, implementation of new private health insurance protections created by the ACA, and additional activities required by legislation.⁶⁰ Mandatory program management appropriations (\$279 million) were established by the following four laws: ACA, ARRA, MIPPA, and ATRA. In addition, the President's FY2014 budget for Program Management includes reimbursable administration⁶¹ (\$951 million) and provisions for new legislative initiatives (\$410 million).

President's Proposal

The President's budget would increase mandatory funding for Program Management by \$400 million to fund implementation of the mandatory health care proposals in the President's budget. The Administration estimated that the \$400 million expenditure for this proposal over the next few years would decrease federal expenditures by approximately \$393 billion over ten years. **This proposal was *not* included in the President's FY2013 budget proposal.**

Survey Revisit User Fee

Current Law

Federal and state governments share responsibility for ensuring that many Medicare providers and suppliers provide quality care and meet certain safety standards. The federal government sets quality and safety requirements that these entities must meet to participate in the Medicare and Medicaid programs. In general, CMS contracts with organizations (often state survey agencies) to conduct periodic inspections and investigate quality or safety complaints. Survey organizations follow federal regulations in conducting inspections or investigations; though some survey activities and policies are set by the surveyors, state agencies, or contractors, including hiring and

⁶⁰ See *Fiscal Year 2014 Budget in Brief, Strengthening Health and Opportunity for all Americans*, U.S. Department of Health and Human Services, April 2013.

⁶¹ Reimbursable administration is offsetting collections from non-federal sources that includes Health Insurance Exchanges, 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.

retaining a surveyor workforce, training surveyors, reviewing deficiency citations, and managing regulatory interactions with the industry and public.

The Medicare and/or Medicaid programs, through state survey agencies, contractors, or other entities, surveys and certifies at least the following providers and suppliers:

- Long-term care facilities,
- Home health agencies,
- Accredited and non-accredited hospitals,
- Organ transplant facilities,
- Dialysis facilities,
- Ambulatory surgical centers,
- Community mental health centers,
- Hospices, and
- Outpatient physical therapy, outpatient rehabilitation, rural health clinics, and portable X-Ray facilities.

The number of participating facilities has continued to grow increasing by 4.3% from FY2012 to FY2014, from 55,800 to 58,200.⁶² CMS estimated that in FY2014 survey and certification entities will complete over 24,000 initial surveys and re-certifications and investigate over 55,000 complaints.⁶³ All facility providers must undergo initial survey and certification inspections when they enroll as providers in Medicare or Medicaid, and on a regular basis thereafter. CMS intends to add inspection requirements for community mental health centers in FY2014.

President's Proposal

The President's budget includes two proposals for new user fees: a Survey and Certification Revisit Fee and a fee to share Medicare data with qualified entities. The Revisit Fee would provide CMS with additional resources to revisit poor performers, while also creating financial incentives for organizations to ensure continuing quality of care. The Revisit Fee would be phased in over a number of years. Fees for expanded data sharing would allow CMS to broaden qualified entities' use of Medicare data for activities such as fraud prevention, care coordination practice improvement, and other value-added analyses. **This proposal was *not* included in the President's FY2013 budget proposal.**

⁶² *Fiscal Year 2014 Budget in Brief, Strengthening Health and Opportunity for All Americans*, Department of Health and Human Services, April 2013.

⁶³ *Ibid.*

Extension of 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 requires the Secretary to have a contract with a consensus-based entity (e.g., National Quality Forum) to carry out specified duties related to performance improvement and measurement.⁶⁴ 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 requires the Secretary to establish a pre-rulemaking process, to include a series of six steps to select quality measures, including gathering multi-stakeholder input; making measures under consideration available to the public; transmission to, and consideration by, the Secretary of the input of multi-stakeholder groups; and the publication of the rationale for the use of any quality measure in the Federal Register; among others.⁶⁵ The Secretary must establish a process for disseminating the selected quality measures and periodically review and determine whether to maintain the use of a measure or to phase it out.

President's Proposal

The President's budget would extend funding for both of the provisions authorizing specified quality and performance measurement duties for a contracted consensus-based entity. The President's budget would fund MIPPA Section 183 at \$10 million per year for each of the fiscal years FY2014 through FY2017. It would also fund ACA Section 3014 at \$20 million per year for each of the fiscal years FY2015 through FY2017. **This proposal was *not* included in the President's FY2013 budget proposal.**

⁶⁴ SSA Section 1890 (42 U.S.C. §1395aaa).

⁶⁵ SSA Section 1890A (42 U.S.C. §1395aaa-1).

Table 6. President's FY2014 Budget—Program Management Legislative Proposals and Estimated Costs

(dollars in millions)

Legislative Proposals	New (N), Modified (M), or Repeated (R) from the President's FY2013 Budget	HHS Cost/Savings Estimates		
		FY2014	FY2014- FY2018	FY2014- FY2023
Provide Mandatory Administrative Resources for Implementation	N	\$100	\$400	\$400
Survey Revisit User Fee	N	-	-	-
Extension of CMS Quality Measurement	N	10	100	100
Total Changes in Outlays from Legislative Proposals		\$110	\$500	\$500

Source: Office of Budget and Management, Summary Table, S-9. Mandatory and Receipt Proposals.

CMS: Centers for Medicare & Medicaid Services

HHS: Health and Human Services.

Comparison to House and Senate Budget Resolutions

Usually, the President's budget request is the first step in the federal budget process. However, this year, both the House and the Senate agreed to budget resolutions⁶⁶ prior to the President submitting his budget request. As shown in **Figure 1**, the President's budget for Function 550 (which includes Medicaid, CHIP, and the health insurance exchanges among a number of other health care programs and activities) varies from both the House and Senate budget resolutions, but as shown in **Figure 2**, the President's budget for Function 570 (which consists of the Medicare program) is similar to funding levels in the House and Senate budget resolutions. The following provides a brief description of the policies included in the House budget resolution and the Senate budget resolution, as compared with the President's FY2014 budget.

House Budget Resolution

On March 12, 2013, House Budget Committee Chairman Paul Ryan released the chairman's mark of the FY2014 House budget resolution together with his report entitled *The Path to Prosperity: A Responsible Balanced Budget*, which outlines his budgetary objectives.⁶⁷ The House Budget Committee considered and amended the chairman's mark on March 13, 2013, and voted to report the budget resolution to the full House. H.Con.Res. 25 was introduced in the House on March 15, 2013 and was accompanied by the committee report (H.Rept. 113-17). H.Con.Res. 25 was agreed to by the House on March 21, 2013 by a vote of 221 to 207.

⁶⁶ A budget resolution provides general budgetary parameters; however, it is not a law. Changes to programs that are assumed or suggested by the budget resolution would still need to be enacted in separate legislation.

⁶⁷ This report may be found at <http://budget.house.gov/uploadedfiles/fy14budget.pdf>.

Chairman Ryan's budget proposal, as outlined in his report and in the committee report, suggests short-term and long-term changes to federal health care programs including Medicare, Medicaid, and the health insurance exchanges established by the ACA.⁶⁸ Within the 10-year budget window (FY2014-FY2023), the House budget resolution assumes that certain ACA provisions would be repealed, including those that expand Medicaid coverage to the non-elderly with incomes up to 133% of FPL, and those provisions that establish health insurance exchanges. The budget proposal also suggests restructuring Medicaid from an individual entitlement program to a block grant program. Additionally, the House resolution assumes a fix to the Sustainable Growth Formula (SGR) used to establish Medicare physician rates, and a repeal of the IPAB. According to the House Budget Committee estimates, the House resolution would reduce health care spending by \$2.7 trillion over the 10-year budget window in comparison to current policies.

Beyond the 10-year budget window, beginning in FY2024, the budget proposal assumes an increase in the age of eligibility for Medicare and the conversion of Medicare to a fixed federal contribution program.

Senate Budget Resolution

On March 13, 2013, Senate Budget Committee Chairman Patty Murray released a report outlining the FY2014 Senate budget resolution entitled *Foundation for Growth: Restoring the Promise of American Opportunity*.⁶⁹ The Senate Budget Committee considered and passed the budget resolution on March 14, 2013. S.Con.Res. 8 was introduced in the Senate on March 15, 2013 and was accompanied by the committee print (S. Prt. 113-12). The Senate passed S.Con.Res. 8 on March 23, 2013 with a vote of 50-49.

In contrast to the House budget resolution, the Senate budget resolution maintains all the changes included in the ACA, including the ACA Medicaid expansion and the health insurance exchanges. According to Senate Budget Committee estimates, the Senate resolution includes \$275 billion in health care savings, which are derived from encouraging health care delivery system reforms (i.e., bundled payments or value-based reimbursement programs) and reducing fraud and abuse. In addition, the Senate budget resolution assumes the costs of a permanent fix to the SGR physician payment system and eliminates the Medicare sequestration cuts.

Comparison

Figure 1 and **Figure 2** compares the outlays provided for Function 550 and Function 570 in the President's budget, the House resolution, and the Senate resolution.

Function 550: Health

Function 550 includes most direct health care services programs, most notably Medicaid. Other health programs in this function fund anti-bioterrorism activities, national biomedical research,

⁶⁸ For more information about the health care changes in the House Budget Resolution, see CRS Report R43017, *Overview of Health Care Changes in the FY2014 Budget Proposal Offered by House Budget Committee Chairman Ryan*, by (name redacted), (name redacted), and (name redacted).

⁶⁹ This report can be found at http://www.budget.senate.gov/democratic/index.cfm/files/serve?File_id=c951a802-7600-4111-97c9-20bcc9c69d8.

activities to protect the health of the general population and workers in their places of employment, health services for under-served populations, and training for the health care workforce. Some of the HHS agencies in this function include the National Institutes of Health, Centers for Disease Control and Prevention, Health Resources and Services Administration, and the Food and Drug Administration. The major mandatory programs in this function are Medicaid, CHIP, federal and retirees' health benefits, and health care for Medicare-eligible military retirees. A vast majority of the spending in Function 550 is attributable to Medicaid. In FY2012, Medicaid accounted for 72.3% of the Function 550 expenditures.⁷⁰

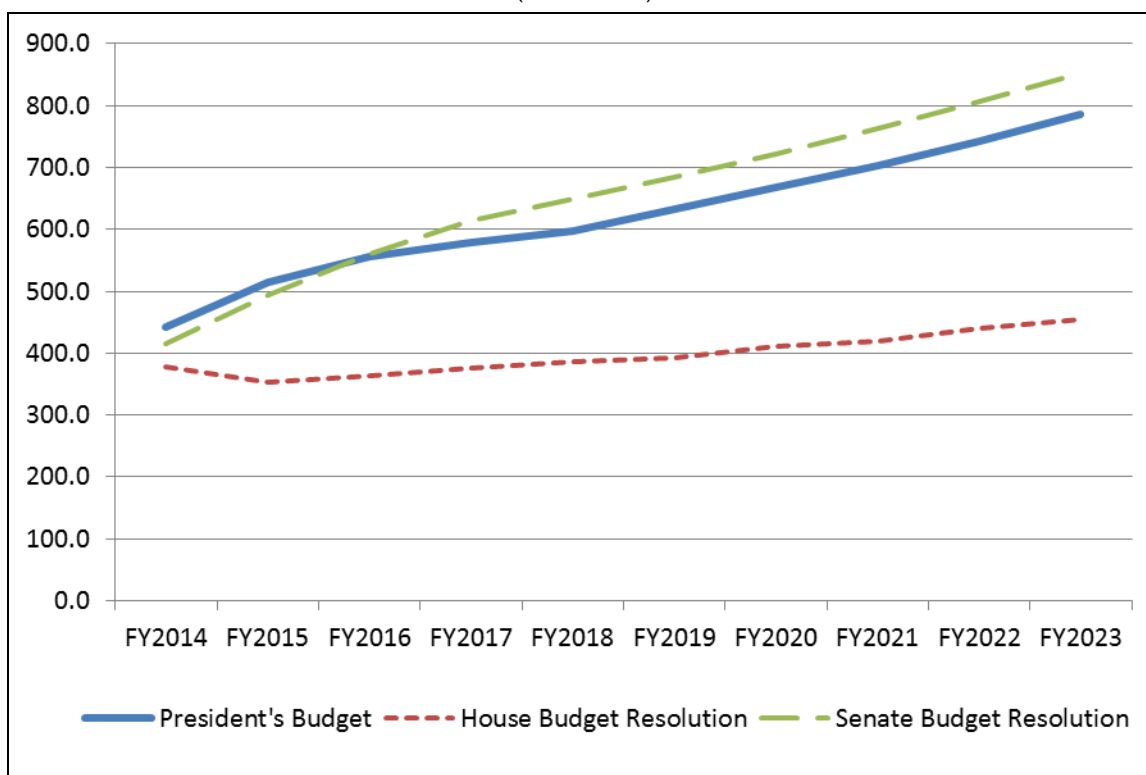
As shown in **Figure 1**, over the next 10 years, the funding for Function 550 varies by budget plan with the House resolution providing significantly less funding for Function 550 when compared to the President's budget and the Senate resolution. This difference is largely attributable to the House resolution including reductions to Medicaid in the amount of \$1.4 trillion over the 10-year budget window, which includes \$636 billion in savings from repealing the ACA Medicaid expansion.⁷¹ The Senate resolution did not specify any Medicaid legislative proposals, while the President's budget includes a number of legislative proposals impacting the Medicaid program (see the "Medicaid Legislative Proposals" and "Program Integrity Legislative Proposals" sections of this report).

⁷⁰ Office of Management and Budget, *Analytical Perspectives – Supplemental Material*, Table 31-1.

⁷¹ House Budget Committee, *The Path to Prosperity: A Responsible, Balanced Budget*, March 2013. This report may be found at <http://budget.house.gov/uploadedfiles/fy14budget.pdf>.

Figure I. Function 550: Health

Comparison of Outlays in President's Budget, House Budget Resolution, and Senate Budget Resolution
(\$ in billions)



Source: Congressional Research Service based on data from H.Con.Res. 25, S.Con.Res. 8, and Office of Management and Budget, FY2014 Analytical Perspectives – Supplemental Material, Table 31-I.

Function 570: Medicare

Function 570 consists of the Medicare program, which pays for covered health care services for individuals age 65 or older and certain persons with disabilities. Nearly 99% of spending in this function is mandatory, and almost all of the mandatory spending consists of payments for Medicare benefits. Congress provides an annual appropriation for the costs of administering and monitoring the Medicare program.

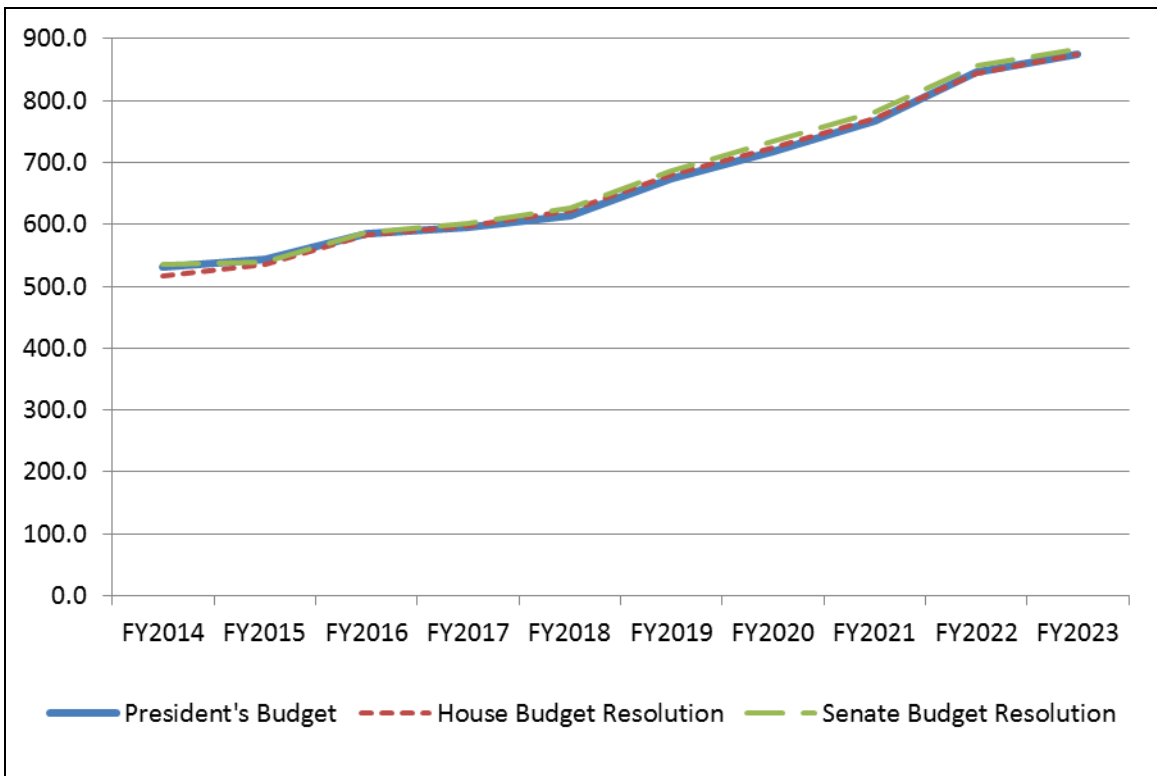
Figure 2 shows estimated outlays for Medicare, from FY2014 through FY2023, under the President's budget, the House resolution, and the Senate resolution. The figure shows relatively little difference between the budgets and the funding for Medicare, with the Senate resolution providing slightly more funding than the others, particularly in the later years. Both the President's budget and the Senate resolution assume that the SGR physician payment system would be fixed, and that the 2% reduction in Medicare benefit spending under sequestration would not take place; these assumptions were incorporated into their respective Medicare spending baselines. The President's budget also includes a number of specific legislative proposals (see the "Medicare Legislative Proposals" and "Medicaid Legislative Proposals" sections of this report) that the Administration estimates will save a net of \$371 billion compared to the baseline over the next ten years. The Senate resolution did not include specific cost-reduction proposals, but the Senate resolution includes savings of \$265 billion over the next ten

years through delivery system changes, increased efforts to reduce fraud and abuse, and greater engagement across the health care system.⁷²

The House budget resolution assumes a fix to the SGR physician payment system plus a repeal of the IPAB, however the resolution did not indicate how the cost increases associated with these two proposals were reflected in their Medicare spending baseline estimates. While the House resolution assumes a slight decrease in Medicare spending (\$129 billion) over the next ten years compared to current CBO baseline projections (which is based on current law and assumes future reductions in physician payments and continuation of the 2% Medicare spending reductions under sequestration), the resolution did not provide specifics on how spending would be reduced to these lower levels, nor whether the 2% benefit reductions under sequestration would continue.

Figure 2. Function 570: Medicare

Comparison of Outlays in President's Budget, House Budget Resolution, and Senate Budget Resolution (\$ in billions)



Source: Congressional Research Service based on data from H.Con.Res. 25, S.Con.Res. 8, and Office of Management and Budget, FY2014 Analytical Perspectives – Supplemental Material, Table 31-I.

⁷² S. Prt. 113-12.

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