BUDGET BULLETIN

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CHAIRMAN MIKE ENZI | @BUDGETBULLETIN

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President's Fiscal Year 2017 Budget Health Care Proposals

by Senate Budget Committee Republican Staff

EDITOR'S NOTE: All Years Are Fiscal Years Unless Otherwise Stated.

The Department of Health and Human Services (HHS), which is responsible for administering most federal health programs, has requested $1.15 trillion in budget authority for 2017, an increase of $33 billion. The HHS budget requests an additional 1,823 full-time equivalent employees (FTEs), which would bring its total number of FTEs to 79,406 in 2017.

Roughly 7 percent of total budget authority requested by the administration for 2017, or $82.8 billion, is for discretionary spending, which at first appears to represent a decrease of $658 million from 2016 levels. While there are some reductions in discretionary programs and accounts proposed in the president's budget submission, such as the $160 million reduction to Project Bioshield, the administration offsets proposed reductions on the discretionary side overall with increases in spending on the mandatory side.

For example, health centers discretionary funding provided through the Health Resources and Services Administration is incorporated into a new mandatory funding proposal ($150 million). The prevalence of this practice of decreasing discretionary spending while increasing mandatory spending on the same activity effectually circumvents the discretionary spending caps currently in law and removes the program from the discipline of the appropriations process.

The budget includes a number of new mandatory spending initiatives in areas that have historically been considered discretionary. The president's proposal cuts discretionary spending at the National Institute of Health (NIH) by $1 billion, but increases mandatory agency spending by more than $1.8 billion. This includes $755 million for the vice president's cancer "moonshot" initiative, which boosts NIH National Cancer Institute funding by $680 million and transfers an additional $75 million to the Food and Drug Administration (FDA). Remaining NIH mandatory spending increases support the president's precision medicine initiative ($100 million) and the "BRAIN" initiative to enhance our understanding of the human brain ($45 million).

Across HHS, $559 million in new mandatory and discretionary funding is provided to address prescription drug abuse in 2017. Included in this amount is a new $1 billion ($500 million in 2017) two-year mandatory funding increase for Substance Abuse and Mental Health Services Administration (SAMHSA) to support state-led evidence-based programs to increase access to treatment and recovery services. Some of the major increases are also requested for improved prescribing practices ($10 million), supporting the development and use of naloxone ($10 million), and expanding the use of medication-assisted treatment ($25 million). Similar to NIH, SAMHSA sees a $95 million reduction to its discretionary budget in 2017, but a $590 million increase in mandatory spending.

The president's budget also proposes $500 million in new two-year mandatory funding for a dedicated mental health initiative, including $115 million in SAMHSA grants to states for early intervention programs, $30 million for a new state suicide prevention demo, $55 million to expand the number of states in the community behavioral health clinic demonstration program, $25 million to increase behavioral health providers at Indian Health Services, and $25 million to provide additional loan repayment awards for behavioral health providers.

The president's budget submission claims a total of approximately $378 billion in mandatory health savings over 10 years. (Note: The $1.9 billion in new mandatory funding for NIH and FDA is not included in these figures.) Details on health care proposals in the president's budget affecting mandatory spending follow.

The budget contains proposals that would affect mandatory health care spending, resulting in a $46 billion net increase in mandatory spending. These health care proposals include:

<u>Increases in spending (+$94 billion):</u>

- Expand Medicaid in Puerto Rico and other U.S. territories (+$29.6 billion).
- Create state option to provide 12-month continuous Medicaid eligibility for adults (+$12.5 billion, with receipts included).
- Reestablish the Medicaid primary care payment increase through calendar year 2017 and include additional providers (+$9.5 billion).
- Extend health centers (+$7.3 billion).
- Add certain behavioral health providers to the Electronic Health Record Incentive Programs (+$4.4 billion, non-Medicare effect).
- Pilot comprehensive long-term-care state plan option (+$4.1 billion).
- Expand eligibility under the Community First Choice option (+$3.9 billion).
- Extend CHIP funding through 2019 (+$2.7 billion, with receipts included).
- Provide enhanced federal match to all Medicaid expansion states (+$2.6 billion).

- Extend special diabetes program at NIH and the Indian Health Service (+$2.5 billion).
- Invest in the National Health Service Corps (+$2.4 billion).
- Provide home and community-based services (HCBS) to children eligible for psychiatric residential treatment facilities (+$1.6 billion).
- Support Children's Hospital GME (+$1.5 billion).
- Extend the performance bonus fund (+$1.4 billion).
- Create a demonstration program to address over-prescription of psychotropic medications for children in foster care (+$1.1 billion).
- Allow states to develop age-specific home health programs (+$1.1 billion).
- Permanently extend Express Lane Eligibility for children (+$870 million).
- Require full coverage of preventive health and tobacco cessation services for adults in traditional Medicaid (+$789 million).
- Support Teaching Health Centers Graduate Medical Education (+$528 million).
- Standardize definition of American Indian and Alaska Native in the Affordable Care Act (ACA) (+$520 million).
- Require coverage of Early and Periodic Screening, Diagnostic, and Treatment program for children in inpatient psychiatric treatment facilities (+$505 million).
- Fund a dedicated Mental Health Initiative (+$500 million).
- Provide CMS Program Management implementation funding (+$400 million).
- Align Medicare Savings Program income and asset definitions with Part D low-income subsidy definitions (+$396 million).
- Provide full Medicaid coverage to pregnant and post-partum beneficiaries (+$375 million).
- Expand eligibility for the 1915(i) HCBS state plan option (+$374 million).
- Extend FEHBP to infants born to daughters of FEHBP enrollees for 30 days (+$345 million).
- Extend 100 percent federal match to all Indian health programs (+$80 million).
- Extend funding for the Adult Health Quality Measures Program (+$70 million).
- Allow CMS to reinvest civil monetary penalties recovered from home health agencies (+$10 million).
- Allow full Medicaid benefits for individuals in a home and community-based services state plan option (+$9 million).

Reductions in spending (-$48 billion):

- Require remittances for medical loss ratios for Medicaid and CHIP managed care (-$23.5 billion).

- Rebase future Medicaid Disproportionate Share Hospital (DSH) allotments (-$6.6 billion).
- Create a federal-state Medicaid negotiating pool for high-cost drugs (-$5.8 billion).
- Correct ACA Medicaid rebate formula for new drug formulations and exempt abuse deterrent formulations (-$4.3 billion).
- Streamline FEHBP pharmacy benefit contracting (-$1.4 billion).
- Adjust FEHBP premiums for wellness (-$1.4 billion).
- Prohibit brand and generic drug companies from delaying the availability of new generic drugs and biologics (-$1.4 billion, non-Medicare effect).
- Exclude brand-name and authorized generic drug prices from the Medicaid Federal upper limit (-$870 million).
- Track high prescribers and utilizers of prescription drugs in Medicaid (-$770 million).
- Eliminate the 190-day lifetime limit on inpatient psychiatric facility services (-$720 million, non-Medicare effect).
- Expand funding for the Medicaid Integrity Program (-$675 million).
- Clarify the Medicaid definition of brand drugs to prevent inappropriately low rebates (-$260 million).
- Exclude authorized generics from Medicaid brand-name rebate calculations (-$200 million).
- Expand FEHBP plan types (-$88 million).
- Expand Medicaid Fraud Control Unit (MFCU) authority review to additional care settings (-$72 million).
- Modify length of exclusivity for biologics (-$70 million, non-Medicare effect).
- Protect program integrity algorithms from disclosure (-$20 million, non-Medicare effect).

Proposals with no budgetary effect:
The budget also includes a number of other health care proposals that according to the administration would not have a budgetary effect. Examples include legislative proposals that would affect private health insurance plans.

In addition, the budget contains proposals that would affect Medicare spending, resulting in a $423 billion net reduction in mandatory spending. These Medicare proposals include:

Increases in spending ($78 billion):

- Eliminate the 190-day lifetime limit on inpatient psychiatric facility services (+$2.4 billion).

- Eliminate beneficiary coinsurance for screening colonoscopies with polyp removal (+$2.4 billion).
- Provide Office of Medicare Hearings and Appeals and Department Appeals Board authority to use RAC collections (+$1.3 billion).
- Add certain behavioral health providers to the Electronic Health Record Incentive Programs (+$760 million).
- Ensure retroactive Part D coverage of newly eligible low-income beneficiaries (+$100 million).
- Update Medicare Disproportionate Share formula for hospitals in Puerto Rico (+$70 million).
- Policy interactions (+$71.3 billion).

<u>Reductions in spending (-$501 billion):</u>

Medicare providers (-$445 billion):

- Align Medicare drug payment policies with Medicaid policies for low-income enrollees (-$121.3 billion).
- Adjust payment updates for certain post-acute care providers (-$86.6 billion).
- Reform Medicare Advantage payments to increase the efficiency and sustainability of the program (-$77.2 billion).
- Strengthen the Independent Payment Advisory Board to reduce long-term drivers of Medicare cost growth (-$36.4 billion).
- Reduce Medicare coverage of bad debts (-$32.9 billion).
- Encourage workforce development through targeted and more accurate indirect medical education payments (-$17.8 billion).
- Prohibit brand and generic drug manufacturers from delaying the availability of new generic drugs and biologics (-$12.3 billion, Medicare effect).
- Accelerate manufacturer discounts for brand drugs in the coverage gap (-$10.2 billion).
- Implement bundled payment for post-acute care (-$9.9 billion).
- Reform Medicare hospice payments (-$9.3 billion).
- Modify reimbursement of Part B drugs (-$7.8 billion).
- Modify length of exclusivity for biologics (-$6.9 billion, Medicare effect).
- Exclude certain services from the in-office ancillary services exception (-$5 billion).
- Provide authority to expand competitive bidding for certain durable medical equipment (-$3.8 billion).
- Encourage appropriate use of inpatient rehabilitation hospitals by requiring that 75 percent of IRF patients require intensive rehabilitation services (-$2.2 billion).
- Reduce waste, fraud, and abuse in Medicare (-$1.9 billion):

  - Retain a portion of Medicare Recovery Audit Contractor recoveries to implement action that prevent fraud and abuse (-$800 million).
  - Suspend coverage and payment for questionable Part D prescriptions and incomplete clinical information (-$780 million).
  - Allow prior authorization for Medicare fee-for-service items (-$75 million).
  - Permit exclusion from Federal Health Care Programs if affiliated with sanctioned cities (-$70 million).
  - Protect program integrity algorithms from disclosure (-$70 million).
  - Allow the Secretary to reject claims for new providers and suppliers located outside moratorium areas (-$50 million).
  - Allow civil monetary penalties for providers and suppliers who fail to update enrollment records (-$32 million).
- Reduce Critical Access Hospital (CAH) payments from 101 percent of reasonable costs to 100 percent of reasonable costs (-$1.7 billion).
- Prohibit CAH designation for facilities that are less than 10 miles from the nearest hospital (-$880 million).
- Require mandatory reporting of other prescription drug coverage (-$480 million).
- Expand the ability of Medicare Advantage organizations to pay for services delivered via telehealth (-$160 million).
- Expand basis for beneficiary assignment for Accountable Care Organizations (ACOs) to include Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists (-$150 million).
- Allow CMS to assign beneficiaries to Federally Qualified Health Centers and Rural Health Clinics participating in the Medicare Shared Savings Program (-$80 million).
- Allow ACOs to pay beneficiaries for primary care visits up to the applicable Medicare cost sharing amount (-$70 million).
- Allow beneficiaries to pay a sum certain to Medicare for future medical items and services (-$65 million).

Medicare structural reforms (-$56 billion):

- Increase income-related premiums under Medicare Parts B and D (-$41.2 billion).
- Encourage the use of generic drugs by low-income beneficiaries (-$9.6 billion).
- Modify the Part B deductible for new beneficiaries (-$4.2 billion).
- Introduce home health co-payments for new beneficiaries (-$1.3 billion).

Proposals with no budgetary effect:

The budget also includes a number of other Medicare proposals that according to the administration would not have a budgetary effect. One example is a legislative proposal that would give the Secretary of Health and Human Services the authority to negotiate prices for biologics and high-cost prescription drugs.