To: All Medicaid Directors  
From: NAMD staff  
Date: February 11, 2016  
Re: President Obama’s Fiscal Year 2017 Budget Proposal  

The following memo provides an overview of President Obama’s fiscal year fiscal year (FY) 2017 budget proposal, outlook for future action, and summarizes the key Medicaid and related proposals that may be of interest to Medicaid Directors. NAMD will continue to notify directors about major legislative activity impacting the Medicaid program and weigh in as appropriate. Please contact Andrea Maresca with questions.

Overview
On February 9, 2016, President Obama unveiled a $4.1 trillion budget, which aims to achieve $375 billion in health care savings over the next decade. These savings are generated primarily by permitting the federal government to negotiate drug prices with manufacturers in Medicare Part D; by raising Medicare premiums for wealthier seniors, and by adjusting payment updates for certain post-acute care providers. The proposal carries over many provisions from previous years.

With regard to Medicaid, the budget would increase federal spending by $22.2 billion over 10 years, driven primarily by a proposal to extend 100% federal match for the first three years a state expands Medicaid, regardless of when the expansion occurs. The budget also focuses in particular on proposals impacting prescription drugs and the Medicaid drug rebate program among others. Also of note is a proposal to grant CMS authority to require remittances from Medicaid managed care plans that fail to meet a medical loss ratio of 85%.

In addition, the budget includes new proposals calling on Congress to enact a two-year funding extension of the Children’s Health Insurance Program (CHIP), through FY 2019. The Administration also proposes a number of other modifications to Medicare financing and delivery models and expresses interest in working with Congress on biologics and high cost specialty drugs.
Outlook

The President’s fiscal year 2017 budget plan lays out a number of major new legislative proposals falling under the broad health care umbrella. Many, such as the proposal to extend the Affordable Care Act’s 100 percent federal financing for the eligibility expansion to adults, are non-starters for the current Republican-controlled Congress. However, the budget document will continue to serve as a resource for the Congress should lawmakers need to identify acceptable offsets for priorities which increase federal expenditures.

Notably, the budget includes proposals that intersect with several major areas of focus for the current Congress. These areas of opportunity include:

- Additional support and changes to the reimbursement methodology and underlying delivery system for mental health-related services. This issue is the subject of ongoing hearings and mark-ups in the House and Senate;
- Providing enhanced tools to address the opioid epidemic;
- Supporting drug innovation, research and development while also addressing high cost drug therapies; and
- Advancing the next wave of changes to transform Medicare health care payment and service delivery.

Congress has a limited number of legislative days remaining in this election year. This will drive lawmakers to focus on opportunities to demonstrate “progress” to their respective constituencies. The potential exists for the House and Senate to advance limited scope bipartisan, bicameral measures and these could reflect some of the Administration’s requests, for example around mental health and the opioid epidemic. In other areas, such as with Medicare delivery system reform, the committees of jurisdiction in the House and Senate are exploring federal policy options which focus on Medicare beneficiaries with chronic conditions as well as program integrity issues. Drug innovation and pricing remains a high profile issue, but it remains unclear whether there is sufficient bipartisan support to advance a proposal in an election year.

Of particular note for Medicaid Directors, CMS is likely to continue the rigorous pace of rulemaking and guidance in the last year of this Administration. The budget highlights a few aspects of the agency’s intended Medicaid regulatory agenda. For example, the budget plan includes a legislative proposal to give CMS explicit authority to apply a medical loss ratio of 85 percent to Medicaid and CHIP managed care plans, consistent with the 2015 proposed rule addressing Medicaid managed care programs. This includes
a requirement that states collect a remittance of any amounts spent in excess of the medical loss ratio and returns the federal share to the federal government. CMS also seeks the flexibility to disallow and defer individual or partial payments associated with Medicaid managed care plans, prepaid inpatient health plans, and prepaid ambulatory health plans. It would allow CMS to tailor deferrals and disallowances to the severity and scope of specific violations.

**Key Budget Documents**

- The Administration’s budget and supporting documents, including appendices are posted at: [http://www.whitehouse.gov/omb/budget](http://www.whitehouse.gov/omb/budget)
- The U.S. Department of Health and Human Services (HHS) budget and supporting documents are posted at: [http://www.hhs.gov/budget/#brief](http://www.hhs.gov/budget/#brief)

**Overview**

*HHS top line numbers.*
The Department of Health and Human Services’ FY17 budget proposal totals $1.144 trillion in outlays and $82.8 billion in discretionary budget authority, a reduction of $600 million in discretionary authority from FY16.

The FY17 budget estimate for the Centers for Medicare and Medicaid Services (CMS) is $1 trillion in mandatory and discretionary outlays, a net increase of $26 billion above the FY16 level. This request covers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), private health insurance programs and oversight, program integrity efforts, and operating costs. The plan’s legislative proposals would have a net impact of $5.6 billion, including $199 million in program integrity investment. Targeted reforms to Medicare are projected result in a net savings of $419.4 billion over ten years.

For FY17, CMS estimates the federal share of Medicaid outlays at approximately $376.6 billion, an increase of $9.4 billion over the FY16 estimate and $26.8 billion relative to the FY15 level.
Focus Area: Opioid Abuse Prevention and Treatment

The Administration proposes a major new investment in preventing opioid abuse and overdose, both in the form of prescription opioids and heroin. The proposal includes $1 billion in mandatory funding over two years, aimed at supporting cooperative agreements with states to expand treatment access, increase access to medication-assisted treatment (MAT) via the National Health Service Corps, and conduct evaluations of MAT. The budget also includes other investments in opioid abuse prevention and treatment programs totaling $599 million. These funds would primarily enhance existing HHS and Department of Justice programs to expand state-level drug overdose prevention initiatives, increase the availability of MAT, and improve access to the opioid overdose-reversal drug naloxone. Other proposals under this area include:

- $85 million for programs to support improved prescribing practices, an increase of $18 million over FY 16; which includes supporting uptake of the CDC’s guidelines for prescribing opioids for chronic pain; and
- An additional $5 million for an ONC program to increase adoption of electronic prescribing of controlled substances.

Focus Area: Addressing High-Cost Prescription Drugs

The FY17 budget indicates a renewed focus by HHS to address the increasingly high costs of new pharmaceutical therapies. It includes proposals impacting both Medicaid and Medicare on this issue, which are detailed below.

Medicaid Prescription Drug Pricing Proposals

- Create a Federal-State Medicaid Negotiating Pool for High-Cost Drugs (−$200 million in FY17, -$5.8 billion over 10 years). This proposal would allow CMS and participating states to jointly partner with a private sector contractor to negotiate supplemental rebates from drug manufacturers.

Medicare Prescription Drug Pricing Proposals

- Proposals to Address Biologics and High Cost Prescription Drugs (no projected budget impact). The budget proposal states the Administration wishes to work with Congress
to address growing pharmaceutical costs. The budget proposes one potential solution that would give the Secretary the authority to negotiate with manufacturers to determine drug prices under the Part D program for biologics, as well as high-cost drugs eligible for placement on a plan’s specialty tier. As a condition of participation in the Part D program, manufacturers must engage in negotiations with HHS. As part of the negotiation, manufacturers would be required to supply HHS with all data and information necessary to come to an agreement on price. The final price would be indexed to the Consumer Price Index and plan sponsors would be permitted to negotiate additional discounts off this price.

- **Accelerate Manufacturer Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap** (*-$10.2 billion over 10 years*). This proposal would speed implementation of the Affordable Care Act’s closure of the Medicare Part D “donut hole” coverage gap by requiring, beginning in 2018, to increase manufacturer discounts on brand drugs to increase from 50% to 75%. This change would accelerate the closure of the coverage gap for brand drugs by 3 years.

- **Modify Reimbursement of Part B Drugs** (*-$7.8 billion over 10 years*). The Administration proposes lowering payment of physician-administered drugs and hospital outpatient drugs from 106% of average sales price to 103% starting in 2017. If the physician’s acquisition cost for a drug exceeds the average sales price plus 3%, the manufacturer is required to provide a rebate to match the average sales price plus 3%, minus an overhead fee determined by the Secretary. The Secretary would also be given authority to pay some or all of the amount above average sales price as a flat fee rather than a percentage, on a budget neutral basis relative to average sales price plus 3%.

- **Require Evidence Development for Coverage of High Cost Drugs** (*no budget impact*). This proposal creates a coverage with evidence development process for Medicare Part D, similar to such processes in Parts A and B. For certain drugs, manufacturers will be required to undertake further clinical trials and data collection to support use in the Medicare population and any relevant subpopulations identified by CMS.

**Other Proposals Impacting Drug Pricing**

- **Establish Transparency and Reporting Requirements in Pharmaceutical Drug Pricing** (*no budget impact*). The Administration proposes that pharmaceutical manufacturers publicly disclose drug production costs, including research and development
investments, and discounts to various payers for specific high-cost drugs identified by the Secretary.

- **Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics** ($12.3 billion in Medicare savings over 10 years). This proposal would, beginning in 2017, prohibit “pay-for-delay” agreements between branded and generic pharmaceutical companies via the Federal Trade Commission.

- **Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics** ($6.9 billion in Medicare savings over 10 years). This proposal would reduce a manufacturer’s exclusivity for biological products from 12 years to 7 years, and prohibit additional years of exclusivity due to minor formulation changes. It would also alter Medicare Part B reimbursement of biosimilars and innovator biologics by basing reimbursement on the weighted average sales price of the reference biological and all its biosimilars.

**FY 2017 Budget: Medicaid Proposals**

The FY17 budget carries forward many of the Medicaid proposals contained in this Administration’s previous budget plans. Still, there are several new Medicaid-specific proposals, including a proposal to extend 100% FMAP for the first 3 years a state expands Medicaid, regardless of when the expansion occurs. Notably, the budget proposes to require remittances from Medicaid managed care plans that fail to meet an 85% medical loss ratio – a proposal originally put forward in the 2015 Medicaid managed proposed rule. Other new proposals impact Medicaid managed care, drug rebate negotiations, and the Medicare-Medicaid dually eligible.

**Medicaid proposals with increased costs**

The budget plan includes several proposals, which would result in a direct increase in state and/or federal costs. The budget also includes other proposals, which have Medicaid implications.

- **Ensure Access to Enhanced FMAP for Medicaid Expansion** ($2.6 billion over 10 years). This proposal would provide all states with 100% federal match for newly eligible Medicaid populations under a Medicaid expansion, regardless of when the state chooses to expand. The enhanced FMAP would eventually decrease to 90% for the
newly eligible Medicaid population on the same timeline as states which expanded Medicaid in 2014 under the ACA.

- **Add Certain Behavioral Health Providers to the Electronic Health Record Incentive Program** ($5.2 billion total federal costs, $4.4 billion in Medicaid costs over 10 years). This proposal would expand the Medicare and Medicaid Electronic Health Record Incentive Programs to include psychiatric hospitals, community mental health centers, residential and outpatient mental health and substance use disorder treatment clinics, and psychologists.

- **Extend 100 Percent Federal Match to All Indian Health Programs** ($6 million in FY17, $80 million over 10 years). This proposal would revise the Medicaid statute to make 100% federal match available for Medicaid services provided to American Indians and Alaska Natives within the whole scope of Indian Health Service/Tribal/Urban service delivery networks.

- **Lift Cap on Medicaid Funding for Puerto Rico and U.S. Territories** ($320 million in FY17, $29.6 billion over 10 years). This proposal would lift the federal cap on Medicaid funding to the Territories and expand eligibility to 100% FPL for territories below this level. It would also raise FMAP for the territories from 55% to 60%, and provide additional incentives for program modernization. Upon demonstration of robust program oversight and full program benefits, the Territories will become eligible for the same federal Medicaid support permitted to the states.

- **Pilot a Comprehensive Long-Term Care State Plan Option** ($4.1 billion over 10 years). The budget proposes a new, eight-year pilot for a comprehensive long-term care state plan option for up to five states. Participating states would be authorized to provide home and community-based care at the nursing facility level of care. HHS seeks Secretarial discretion to make the pilots permanent at the end of the eight years.

- **Allow States to Develop Age-Specific Health Home Programs** ($1.1 billion over 10 years). This proposal would allow states to target their Health Home programs by age.

- **Expand Eligibility for the 1915(i) Home and Community-Based Services State Plan Option** ($7 million in FY17, $3.9 billion over 10 years). The budget proposes to update eligibility requirements to increase states’ flexibility in expanding access to home and community-based services under section 1915(i).
- **Allow Full Medicaid Benefits for Individuals in a Home and Community-Based Services State Plan Option** ($9 million in costs over 10 years). This proposal would provide states with the option to offer full Medicaid eligibility to medically needy individuals who access HCBS through the state plan option under section 1915(i).

- **Expand Eligibility under the Community First Choice Option** ($255 million in FY17, $3.9 billion over 10 years). The budget proposes to provide states with the option to make medical assistance available to individuals who would be eligible under the state plan if they were in a nursing facility. The Administration states this would provide states with additional tools to manage their HCBS delivery systems.

- **State Option for 12-Month Continuous Medicaid Eligibility for Adults** ($11.1 billion in federal costs, including $34.9 billion in Medicaid costs over ten years; related impacts on marketplace subsidies). The Administration seeks to create a state plan option to allow 12-month continuous eligibility for adults determined eligible for Medicaid on the basis of Modified Adjusted Gross Income.

- **Extend Enhanced Primary Care Reimbursement** ($7.6 billion in FY2017, $9.5 billion over 10 years). As part of its set of proposals to support delivery system reform, the Administration proposes a two-year extension of the Medicaid Primary Care Payment Increase through calendar year 2017. The proposal would include mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes.

- **Provide HCB Waiver Services to Children and Youth Eligible for Psychiatric Residential Treatment Facilities (PRTFs)** ($1.6 billion over ten years). The Administration proposes to provide states with additional tools to manage their children’s mental health care service delivery systems by expanding the non-institutional options available to these Medicaid beneficiaries. The Administration states that by adding PRTFs to the list of qualified inpatient facilities, Medicaid can provide access to home and community-based waiver services for children and youth in Medicaid who are currently institutionalized and/or meet the institutional level of care.

- **Provide Full Medicaid Coverage to Pregnant and Postpartum Beneficiaries** ($30 million in FY17, $375 million over 10 years). This new proposal would require states to
provide full state plan benefits to all pregnant and post-partum Medicaid beneficiaries.

- **Require Full Coverage of Preventive Health and Tobacco Cessation Services for Adults in Traditional Medicaid** ($99 million in FY2017, $789 million over 10 years) The budget proposes to require coverage of preventive health services as defined in section 2713 of the Public Health Service Act without cost-sharing for all adults enrolled in the Medicaid program. It would also expand section 4107 of the ACA, regarding tobacco cessation services to all Medicaid eligible populations.

- **Require EPSDT Benefits for Children in Inpatient Psychiatric Treatment Facilities** ($35 million in FY17, $505 million over 10 years). Medicaid enrollees under age 21 can receive inpatient psychiatric services, but are excluded from coverage of comprehensive preventive and medically necessary items and services. The Administration proposes to lift the federal Medicaid exclusion of comprehensive children’s.

- **Permanently Extend Express Lane Eligibility Option for Children** ($30 million in FY18, $870 million over 10 years). The budget proposes to permanently extend state Medicaid or CHIP agency authority to use another public program’s eligibility findings to streamline eligibility and enrollment into Medicaid or CHIP. As of January 1, 2016, 14 states and 1 territory used this authority.

**Medicaid proposals to reduce federal spending**
The budget includes the following legislative proposals which are projected to reduce federal Medicaid expenditures.

- **Require Remittances for Medical Loss Ratios for Medicaid and CHIP Managed Care** ($-100 million in FY19, -$23.5 billion over 10 years). This proposal would give CMS authority to apply an 85% medical loss ratio (MLR) to Medicaid and CHIP managed care plans, and require states to collect a remittance on any amounts spent in excess of the MLR. The federal share of the remittance must be returned to the federal government.

- **Rebase Disproportionate Share Hospital (DSH)** ($-6.6 billion over 10 years). The President’s budget proposes to continue the current policy, approved in the Affordable Care Act, for lower DSH allotments to align Medicaid DSH payments with reductions in the number of uninsured. The ACA and subsequent statutory
changes reduce state DSH allotments through FY 2025. The budget goes on to propose that DSH allotments for FY 2026 and beyond be based on states’ actual prior year allotments as reduced by the ACA and subsequent legislation, rather than having FY 2026 and beyond DSH allotments revert to pre-ACA levels.

- **Clarify Medicaid Drug Rebate and Payment Definitions and Calculations** (-$481 million in FY17, -$5.6 billion over 10 years). The Administration’s budget proposes to:
  - Clarify the definition of brand drugs by removing the word “original” from the definition of single source and innovator multiple source drugs and clarify that over-the-counter (OTC) drugs that are approved under a new drug application are considered brand drugs; (-$21 million in FY17, -$260 million over 10 years)
  - Clarify that certain prenatal vitamins and fluoride preparations are covered outpatient drugs and clarify that states must cover these products under the Medicaid Drug Rebate Program if prescribed by a physician;
  - Correct a technical error to the ACA’s alternative rebate for new drug formulations (line extension drugs) to include the basic unit rebate amount for consistency with other drug rebate calculations; (-$410 million in FY17; -$4.3 billion over ten years);
  - Limits to twelve quarters the timeframe for which manufacturers can dispute state utilization data (*no budget impact*);
  - Excludes authorized generic drugs from average manufacturer price calculations for determining manufacturer rebate obligations for brand drugs (-$20 million in FY17, -$200 million over ten years);
  - Remove brand-name drugs (innovator multiple source drugs) and authorized generic drugs from the calculation of Medicaid Federal Upper Limits (FUL) (-$30 million in FY17, -$870 million over ten years); and
  - Exempt emergency drug supply programs from Medicaid drug rebate calculations (*no budget impact*).

**Medicaid proposals with no budgetary impact.**

The budget also retains two previous proposals with no projected federal budgetary impact.

- **Expand state authority to offer benchmark benefit packages.** The budget includes a proposal to extend state authority to require benchmark equivalent benefit coverage for non-elderly, non-disabled adults with income that exceeds 133 percent of the FPL.
States currently have the option to provide certain populations with alternative benchmark benefit packages in place of the benefits covered under a traditional Medicaid state plan.

- **Streamline certain Medicaid appeals processes.** The budget proposes to grant states flexibility to arrange their fair hearings processes to function in a more streamlined, coordinated way by eliminating the requirement to provide a fair hearing at the state Medicaid agency for certain types of appeals when a state has delegated fair hearings to a Marketplace appeals entity or the Secretary of HHS.

**CHIP**

- **Extend CHIP funding, contingency fund, and performance fund through FY 2019 ($3 billion over ten years).** The budget proposes to extend funding for CHIP for four years through FY 2019. It would also extend the contingency fund and the performance bonus fund authorizations through 2019.

**Medicaid demonstration programs**

The budget discusses, but does not propose extending, three existing demonstration programs. These include the following:

- Medicaid Emergency Psychiatric Demonstration
- Incentives for Prevention of Chronic Diseases (funding expires Dec. 31, 2015)
- Money Follows the Person (funding expires Sept. 31, 2016)

**Legislative proposals:**

- **Expand the Certified Community Behavioral Health Clinic Demonstration ($110 million over 10 years).** The Administration proposes expanding the Certified Community Behavioral Health Clinic (CCBHC) demonstration under section 223 of the Protecting Access to Medicare Act of 2014 to an additional 6 states.

- **Medicaid Demonstration: Over-Prescription of Psychotropic Medications for Children in Foster Care.** The Administration proposes $500 million for a new Medicaid demonstration in partnership with the Administration for Children and Families (ACF) to provide performance-based incentive payments to states through Medicaid, coupled with $250 million in mandatory child welfare funding to support state infrastructure and capacity building. This approach is intended to encourage the
use of evidence-based screening, assessment, and treatment of trauma and mental health disorders among children and youth in foster care in order to reduce the over-prescription of psychotropic medications. The budget projects an additional $567 million in Medicaid costs associated with the demonstration in addition to the grant funds and child welfare funding.

**Medicare-Medicaid dually eligible population**

This year’s budget adds one new proposal impacting dual eligible to those included in previous budgets. None have a budget impact.

- **Allow for Federal/State Coordinated Review of D-SNP Marketing Materials**: This new proposal seeks to provide CMS flexibility with rules around the review of marketing materials provided by Dual Special Needs Plans (D-SNPs) to beneficiaries. CMS believes that coordinated reviews of marketing materials for compatibility with a unified set of standards will reduce the burden on CMS and the states, while also potentially improving the quality of the products available to beneficiaries.

- **Integrate the appeals process for Medicare-Medicaid enrollees**. The proposal calls for granting the Secretary the authority to implement a streamlined appeals process for Medicare-Medicaid beneficiaries by allowing for more efficient integration of program rules and requirements.

- **Ensure retroactive Part D coverage of newly eligible low-income beneficiaries**. The budget proposes to give new authority to CMS to contract with a single plan to provide Part D coverage to low-income beneficiaries while their eligibility is processed. This plan would serve as the single point of contact for beneficiaries seeking reimbursement for retroactive claims. Under the Administration’s proposal, the plan would be paid using an alternative methodology whereby payments are closer to actual costs incurred by beneficiaries during this period. CMS states that an existing demonstration using this approach has proven to be more efficient and less disruptive to beneficiaries, but is set to expire at the end of calendar year 2019.

- **Pilot Program of All-Inclusive Care for the Elderly (PACE) to Individuals between Ages 21 and 55**. Under current law, PACE is limited to individuals who are 55 years old or older and who meet, among other requirements, the state’s nursing facility level of care. The Administration proposes to create a pilot demonstration in selected states to expand eligibility to qualifying individuals between 21 years and 55 years.
The pilot would test whether the PACE can effectively serve a younger population without increasing costs.

**Program integrity**

The budget plan includes several program integrity related proposals designed to reduce waste, fraud and abuse. Three of these would lower federal expenditures over the ten year period 2014-2024.

- **Medicaid Program Integrity.** The budget includes an additional $675 million for the Medicaid Integrity Program over ten years, starting with $60 million in FY2017 and gradually increasing to an additional $80 million in FY2026. CMS intends to focus new resources on identified program vulnerabilities, citing its expansion of Medicaid Financial Management program reviews of state financing practices and updates to Medicaid claims and oversight systems to enhance auditing.

- **Strengthen CMS compliance tools in Medicaid managed care** *(no budget impact).* This proposal would provide CMS flexibility to disallow and defer individual or partial payments associated with managed care plans, prepaid inpatient health plans, and prepaid ambulatory health plans. It would allow CMS to tailor deferrals and disallowances to the severity and scope of specific violations.

- **Require states to suspend Medicaid payments when the Secretary determines a significant risk of fraud** *(no budget impact).* This proposal would allow the Secretary to require states to suspend Medicaid payments to providers when the Secretary determines the providers pose a significant risk of fraud, unless the state Medicaid agency demonstrates that the benefits of continued payments outweigh this risk of losses to fraud.

- **Consolidate error rate programs.** The budget includes a proposal to consolidate redundant error rate measurement programs (PERM and MEQC) to create a streamlined audit program with meaningful outcomes.

- **Clarify non-federal share rules.** The Administration proposes to prevent states from using federal funds to pay the state share of Medicaid/CHIP, unless specifically authorized under law to match Medicaid/CHIP funds.
• **Expand Medicaid Fraud Control Unit (MFCU) review to additional care settings.** The Administration proposes to extend federal matching funds for the MFCU’s investigation or prosecution of abuse and neglect to health services delivered in-home and in community-based settings.

• **Track high prescribers and utilizers of prescription drugs ($30 million in FY17, $770 million over ten years).** Require states to monitor high-risk billing activity to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in Medicaid. States would be required to choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes to improve Medicaid integrity and beneficiary quality of care.

• **Tighten compliance for the Medicaid drug rebate program.** The budget includes five proposals related to the Medicaid drug rebate program (*no budget impact projected*).
  - The budget would require drug manufacturers to fully repay states for any covered outpatient drug if the manufacture improperly reported non-drug products to CMS or reported drugs that the FDA found to be less effective.
  - The budget proposes to require regular surveys and audits of drug manufacturers’ compliance with the requirements of Medicaid drug rebate agreements, to the extent they are cost effective.
  - The Administration proposes to increase the statutory civil monetary penalties on manufacturers that knowingly report false information under their drug rebate agreements for calculation of Medicaid rebates.
  - Apply the Medicare requirement that drugs must be listed under FDA law to receive Part D coverage to Medicaid.
  - Provide CMS the authority to collect wholesale acquisition costs for all Medicaid-covered drugs to ensure accurate reporting of average manufacturer prices.

Additional proposals in the budget which apply to both Medicare and Medicaid include the following:

• **Authority for the Healthcare Fraud Prevention Partnership (HFPP):** This proposal would give the authority to accept gifts made to the Trust Funds to support specific activities funded through the HCFAC Account, such as the HFPP. As a result, public and private partners could support the anti-fraud program.
• **Exclusions** (-$70 million over 10 years): The budget includes a proposal to expand authority for permissive exclusion from federal health care programs to individuals and entities affiliated with sanctioned entities. This would close a loophole that currently prevents the Office of the Inspector General (OIG) from excluding certain individuals from Medicare, Medicaid, and CHIP.

• **Protect Program Integrity Algorithms from Disclosure** (-$90 million over 10 years). This proposal is intended to facilitate federal and state sharing of program integrity-related predictive models and algorithms by protecting these algorithms from disclosure.

• **Allow the Secretary to Reject Claims from New Providers and Suppliers Located Outside Moratorium Areas** (-$50 million over 10 years). The Affordable Care Act allowed CMS to impose temporary moratoria on enrollment of certain provider types and suppliers in specific geographic areas to avoid overabundance and overutilization of services. This proposal would grant the Secretary the ability to reject claims from providers and suppliers who circumvent these moratoria by enrolling in localities adjacent to the affected areas.

**Health Care Fraud and Abuse Control (HCFAC) activities and Medicaid Program Integrity.** The FY 2017 budget includes a total of $1.3 billion in mandatory HCFAC. HHS seeks $725 million in discretionary funding, a $44 million increase from FY 2016. HCFAC supports activities such as reducing improper payments, the Fraud Prevention and Enforcement Action Team imitative, and the Fraud Prevention System, among others.

**Notable Medicare Proposals**

• **Establish Authority for a Medicare Part D Prescription Drug Abuse Prevention Program** (no budget impact projected). HHS seeks authority to establish a program in Part D that would require that high-risk Medicare beneficiaries only utilize certain prescribers and/or pharmacies to obtain controlled substance prescriptions, similar to many state Medicaid programs. The Medicare program would be required to ensure that beneficiaries retain reasonable access to high quality services.

**Medicare Delivery System Reform Proposals**

• **Reform Medicare Advantage to Improve the Efficiency and Sustainability of the Program** (-$77.2 billion over 10 years). The Administration proposes to establish
competitive bidding in the Medicare Advantage program. Plans would be paid based on adjusted benchmark, calculated as the lesser of the current law FFS benchmark or the average Medicare Advantage plan bid plus 5%. Plans would be able to fully retain the full difference between their bids and the benchmark. The proposal would also standardize quality bonus payments across counties by removing the doubling of quality payments in certain areas and removing the cap on benchmarks for plans eligible for quality payments.

- **Implement Bundled Payment for Post-Acute Care** ($9.9 billion over 10 years). The budget proposes implementing bundled payments for post-acute care providers, including long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health providers. The proposal would go into effect starting in 2021 and affect at least half of total post-acute provider payments. Rates based on patient characteristics and other factors would be set to produce a permanent and total cumulative adjustment of 2.85% by 2023. Beneficiary coinsurance rates would be unchanged under the proposal.

- **Expand Medicare Shared Savings Program Basis for Beneficiary Assignment to New Primary Care-Furnishing Entities** ($230 million over 10 years). The budget includes two new proposals related to beneficiary assignment under the Medicare Shared Savings Program. The first would allow beneficiaries to be assigned to Accountable Care Organizations (ACOs) based on primary care services delivered by nurse practitioners, physician assistants, and clinical nurse specialists. This would save $150 million over 10 years. The second proposal would allow beneficiaries to be assigned to ACOs based on primary care services furnished by Federally Qualified Health Centers and Rural Health Clinics, and would save $80 million over 10 years.

- **Allow ACOs to Pay Beneficiaries for Primary Care Visits up to the Applicable Medicare Cost-Sharing Amount** ($70 million over 10 years). The budget proposes allowing Medicare ACOs participating in the two-sided risk model to pay beneficiaries for a primary care visit. The ACO will be able to pay for part or all of the Medicare cost sharing requirement for beneficiaries with no supplemental insurance, and may make payments up to the cost sharing amount to beneficiaries with supplemental insurance. Participation is voluntary and no additional payments would be made to cover the costs of this investment.

- **Establish a Bonus Payment for Hospitals Cooperating with Certain Alternative Payment Models** (no budget impact). The budget proposes that, starting in 2022,
hospitals furnishing a certain proportion of services through alternative payment entities will receive a bonus payment. This payment would be accounted for via permanent modification to the Inpatient Prospective Payment System and a temporarily through the Outpatient Prospective Payment System through 2024. Qualifying hospitals will receive an upward adjustment to their base payments each year. Modifications to all providers via the inpatient and outpatient reimbursement systems would ensure budget neutrality.

- **Establish a Hospital-Wide Readmissions Reduction Measure** (*no budget impact*). This proposal would revise the Hospital Readmissions Reduction Program to allow a comprehensive Hospital-Wide Readmission Measure encompassing multiple condition categories, rather than the current discrete “applicable conditions.”

- **Establish Quality Bonus Payments for High-Performing Part D Plans** (*no budget impact*). This proposal would allow Medicare Part D payment methodology revisions to reimburse plans based on quality star ratings. Medicare would increase its subsidy of bids for plans with four or more stars, and reduce its subsidy for plans with lower ratings. This proposal would not alter risk corridor payments, reinsurance, low-income subsidies, or other components of Part D payments, and would be implemented in a budget-neutral manner.

- **Extend Accountability for Hospital-Acquired Conditions** (*no budget impact*). This proposal would require hospitals to code conditions as “present on arrival” rather than “present on admission” for purposes of Medicare Hospital Acquired Conditions payment policy and quality reporting.

- **Implement Value-Based Purchasing for Additional Providers** (*no budget impact*). The budget proposes implementing budget-neutral value-based purchasing programs for additional provider types, including skilled nursing facilities, home health agencies, ambulatory surgical centers, hospital outpatient departments, and community mental health centers. The programs would begin in 2018. At least 2% of payments would be tied to quality and efficiency of care in the first 2 years of implementation and at least 5% beginning in 2020.

**Medicare Proposals to Enhance Care Delivery**

- **Expand the Ability of Medicare Advantage Organizations to Pay for Telehealth Services** (*-$160 million over 10 years*). This proposal would grant the HHS Secretary
discretion to expand Medicare Advantage telehealth service delivery by eliminating otherwise applicable Medicare Part B requirements that certain covered services be provided exclusively through face-to-face encounters.

- **Allow the Secretary to Introduce Primary Care Payments under the Physician Fee Schedule** (*no budget impact*). This proposal would allow the HHS Secretary to introduce additional primary care payments into the Medicare Physician Fee Schedule in a budget neutral manner. These per-beneficiary payments would be equivalent to those which expired under the Medicare primary care incentive program, and would be exempt from beneficiary cost sharing.

*Medicare Proposals to Increase Value in Provider Payments*

- **Eliminate the 190-day Limit on Inpatient Psychiatric Facility Services (IPFS) stays** (*$1.7 billion over ten years*). The budget proposes to eliminate the 190-day Lifetime Limit.

- **Increase the Minimum Medicare Advantage Coding Intensity Adjustment** (*-$3.2 billion over ten years*). Starting in 2017, this proposal changes the yearly increase to the minimum coding intensity adjustment from 0.25 to 0.67 percentage points until the minimum adjustment plateaus at 8.76 percent in 2021 and thereafter.

- **Reduce Medicare Coverage of Bad Debts** (*-$32.9 billion over 10 years*). The budget proposes to reduce bad debt payments to 25 percent over 3 years for all providers who receive bad debt payments, starting in 2017.

- **Reduce Critical Access Hospital Reimbursements to 100% of Costs** (*-$1.7 billion over 10 years*). Medicare currently reimburses CAHs at 101 percent of reasonable costs. This proposal would reduce this rate to 100 percent beginning in 2017.

- **Inpatient Rehabilitation Facilities (IRF) Classification** (*$2.2 billion in savings over 10 years*): The Administration proposes to adjust the standard for classifying a facility as an IRF. Under current law, at least 60 percent of patient cases admitted to IRF must meet one or more of 13 designated severity conditions. This standard was changed to 60 percent from 75 percent in the Medicare, Medicaid, and CHIP Extension Act of 2007. Beginning in 2017, this proposal would reinstitute the 75 percent standard.
- **Medicare home health co-payments** ($-1.3 billion over ten years). The Administration again proposes to impose a $100 copayment per home health episode for new beneficiaries, beginning in 2020. The co-payment would apply for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay. Unless waived for low-income beneficiaries, this could be a direct cost shift to Medicaid via the dually eligible population.

- **Modify Part B deductible for new beneficiaries** ($-4.2 billion over 10 years). The Administration proposes to apply a $25 increase to the Medicare Part B deductible in 2020, 2022, and 2024 for new beneficiaries.

- **Extend Medicaid drug rebate program** ($-121.3 billion over ten years). The President’s budget proposes that beginning in 2018 manufacturers should pay the difference between rebate levels they already provide Part D plans and the Medicaid rebate levels for beneficiaries who receive the Part D Low-Income Subsidy (LIS). The proposal does not discuss what if any impact this may have for state’s Part D clawback payments or potential indirect impacts on Medicaid drug rebates.

- **Encourage Use of Generic Drugs by Low Income Beneficiaries** ($-9.6 billion over 10 years). Beginning in plan year 2018, this proposal seeks to encourage greater generic utilization by lowering copayments for generic drugs. The Secretary would have new authority to exclude therapeutic classes from this policy. Beneficiaries could also obtain brand drugs at current law cost-sharing levels with a successful appeal of a coverage determination. Low-income beneficiaries qualifying for institutional care would be excluded from this policy.

- **Increase Income Related Premiums under Medicare Parts B and D** ($-41.2 billion over 10 years). Beginning in 2020, the budget again proposes to restructure income-related premiums under Medicare Parts B and D by increasing the applicable percent for calculating the lowest income-related premiums by five percentage points, from 35 percent to 40 percent of program costs, and creating new tiers every 12.5 percentage points until capping the highest tier at 90 percent.

**Snapshot: Proposals Impacting Medicaid and State Health Programs**

- **Addressing Viral Hepatitis.** The budget proposes $9 million for a new HRSA program to provide hepatitis C screening and treatment for persons living with HIV. It also allocates $1.1 billion to the CDC’s HIV/AIDS, viral hepatitis, sexually
transmitted infections, and tuberculosis prevention program, a $5 million increase from FY16. This program supports screening and treatment efforts for these conditions.

- **340B Prescription Drug Discount Program.** The budget proposes $17 million for the 340B program, an increase of $7 million. It calls for an additional $9 million to establish a user fee as a long-term financing strategy to support program activities. The budget also requests additional authority to enhance program integrity in the 340B program.

- **Advancing Health Information Technology Interoperability.** The budget provides $82 million for the Office of the National Coordinator for Health Information Technology (ONC), an increase of $22 million from FY16. ONC will continue its work implementing the draft roadmap on interoperability throughout 2017, including reaching the goal of allowing individuals and providers to send, receive, find and use a common set of electronic clinical information nationally by the end of the year. The ONC’s draft roadmap also notes that “current fee-for-service payment policies often deter the exchange of electronic health information, even when it is technically feasible” and says payers need to “evolve policy and funding levers” to help create the economic incentives for interoperable health IT. The draft roadmap lays out markers for what interoperability efforts could look like in three years, six years, and ultimately reaching interoperability in 10 years.

- **Mental health investments.** Generally, the Substance Abuse and Mental Health Services Administration seeks $4.32 billion for FY2017, a $590 million increase from last year. The Administration continues its focus on initiatives to improve mental health prevention, identification and treatment programs, particularly for the most vulnerable populations. Much of the above-referenced opioid overdose funding is reflected in enhanced SAMHSA funding. Of particular interest are the following proposals:
  - Level funding at $1.86 billion for the Substance Abuse Prevention and Treatment Block Grant and level funding at $533 million for the Mental Health Services Block Grant.
  - $115 million in mandatory funding FY 2017 and FY 2018 for a new evidence-based early interventions program for persons with serious mental illness.
  - Maintains a $15 million investment in Assisted Outpatient Treatment for Individuals with Serious Mental Illness.
• Maintains $12 million in Grants to Prevent Prescription Drug/Opioid Related Deaths.
• $10 million in new funding for Crisis Systems, an initiative to support states and communities in developing robust addiction and mental health crisis-response systems.

- **HRSA and Health center funding.** This is the final year of the ACA’s mandatory funding for the Health Center Program. These resources are in addition to the annual discretionary funding amounts Congress approves. The Administration requests $5.1 billion for health center services in FY 2017, including $3.6 billion in mandatory funds to extend current mandatory funding for two years, into FY 2018 and FY 2019.

- **Maternal and Child Health Services Block Grant.** The budget proposes to level fund, at $638 million, the Title V MCH Services Block Grant. As in previous years, the budget seeks to extend and expand the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV).

- **HIV/AIDS.** The budget proposes $2.3 billion for the Health Resources and Services Administration’s Ryan White program.

- **Administration for Community Living (ACL).** The budget requests $2 billion for ACL, an increase of $28 million over last year. The request includes $8 million for the Aging and Disability Resource Centers (ADRCs) program. The budget again supports the Administration for Community Living’s (ACL’s) new initiative to develop best practices and an evidence base to better support young people with intellectual and developmental disabilities as they transition from adolescence into young adulthood across all systems.

- **Justice and Mental Health Collaboration Program (formerly Mentally Ill Offender Act Program).** The budget calls for $14 million for a program to provide grants, training, and technical and strategic planning assistance to help state, local, and tribal governments develop strategies that bring together criminal justice, social services, and public health agencies, as well as community organizations, to develop system-wide responses to the needs of mentally ill individuals involved in the criminal justice system.
- Housing assistance for persons with disabilities. The Budget requests $154 million for the Housing and Urban Development (HUD) Housing for Persons with Disabilities program (known as "Section 811") to continue current assistance and expand this housing by about 700 units. This request includes $152 million for Project Rental Assistance Contract (PRAC) and Project Assistance Contract (PAC) renewals and amendments to fully fund 2,350 housing properties with more than 27,000 units. More information on the Section 811 Funding Request is here: http://portal.hud.gov/hudportal/documents/huddoc?id=27-HSNGrPersons.w.Disab.pdf