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in the news

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Health Reform and Related Health Policy News

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On Feb. 2, 2015, President Barack Obama submitted his fiscal year 2016 budget to the Congress. While congressional Republicans immediately rejected the plan, the budget proposal illustrates the President's priorities for the next fiscal year. The budget plans also include a number of savings in health care, particularly in Medicare, that Congress may eventually adopt either to reduce spending or as funding offsets for other priorities. These savings also may become targets for budget saving or offsets in the future. Republicans in Congress will respond with their own budget proposal and although they rejected the overall proposal, the savings in health care in the President's plan also may be used by the Republicans.

Overall, the proposed $4 trillion budget would increase the deficit by $474 billion, or 2.5 percent of the gross domestic product. Policies proposed in the budget would add approximately $5.7 trillion to the national debt, compared to an approximate $8 trillion under current law. The President would eliminate the sequestration process that would exceed the current discretionary spending caps by $74 billion. Within the proposed higher spending caps, the President proposes $40 billion, or 8 percent, above the current fiscal year. The discretionary spending proposals open the door for possible Administration-Congressional negotiations to raise the discretionary spending cap.

Health Proposals

Department of Health & Human Services

The budget proposes $83.8 billion in discretionary spending for the Department of Health and Human Services (HHS).

Medicare

The budget includes Medicare legislative proposals that are estimated to save almost $390 billion over 10 years, most of which would come from providers. The Medicare proposals are intended to reform the care delivery system, increase the value of Medicare providers' payments, structurally reform Medicare and its appeals process, and continue implementation of Affordable Care Act (ACA) Medicare reforms.

Medicare physician payments are assumed to be frozen at current rates but the budget proposed to repeal the Medicare sustainable growth rate (SGR) payment system. The specifics of the payment alternative are not included in the budget, but notes last year's legislative efforts. The budget estimates that replacing the SGR would cost $44 billion over 10 years. HHS Secretary Sylvia Burwell signaled support for the legislation from the 113th Congress when she stated that, "The administration supports the type of bipartisan, bicameral efforts that Congress undertook last year."

Immediately after the President's budget was submitted to Congress, the Congressional Budget Office (CBO) projected a 10-year freeze in Medicare physician payments at $137.4 billion. CBO also updated the estimate of last year's compromise SGR legislation from $144 billion to $177.4 over 10 years. The increases in costs are the results of using some of the budget offsets that are no longer available to pay for a permanent repeal of the SGR.

Primary care physicians would benefit from the budget's proposed conversion of the ACA's temporary 10 percent Medicare primary care incentive payment program to a permanent program. The budget assumes this program would be made permanent in a budget neutral manner within the Medicare Physician Fee Schedule.

The budget would also amend the physician self-referral in -office ancillary services exemption. Effective calendar year 2017, the budget would prohibit self-referrals for radiation therapy, therapy services, advanced imaging, and anatomic pathology services, except in cases of a clinically integrated practice that has demonstrated cost containment.

For hospitals, the budget would revise the Hospital Readmission Reduction Program to use a Hospital-Wide Readmissions measure based on broad categories of conditions. Hospitals also would be required to code conditions as "present on arrival" and not "present on admission" to meet Medicare Hospital Acquired Conditions payment and reporting requirements.

The budget would reduce payments for Critical Access Hospitals (CAH) from 101 percent of reasonable costs to 100 percent for a savings of $1.7 billion over 10 years. In addition, the budget would prohibit the CAH designation for hospitals that are within 10 miles of another hospital. This would save $770 million over 10 years.

The budget addresses Medicare Disproportionate Share Hospital (DSH) payments. Under the proposed change, individuals who have exhausted Part A inpatient benefits or who have enrolled in a Medicare Advantage plan would be included in the Medicare fraction of the hospitals' DSH patient percentages.

Post-acute care providers would experience payment reductions in several ways. The budget would reduce the market basket update for inpatient rehabilitation facilities, long-term care hospitals, and home health agencies by 1.1 percentage points in each year from 2016 through 2025. Payment updates for these providers would not drop below zero as a result of this proposal. For skilled nursing facilities, the budget would reduce market basket updates under an accelerated schedule, beginning with a -2.5 percent update in FY 2016 tapering down to a -0.97 percent update in FY 2023.

For post-acute care, the budget would also save $9.3 billion over 10 years by implementing a bundled payment for post-acute care providers, including long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health providers.

Medicare prescription drug policies would be changed. The budget proposes to align Medicare drug payment policies with Medicaid policies for low-income beneficiaries by requiring drug manufacturers to pay the difference between the rebate level they already provide Part D plans and the Medicaid rebate level. In addition, manufacturers would be required to provide an additional rebate for drugs with prices that increase faster than inflation.

Medicare payment for Part B drugs would be reduced by lowering the payment from 106 percent of the average sales price (ASP) to 103 percent. If a physician's cost for purchasing the drug exceeds ASP plus 3 percent the drug manufacturer would be required to provide a rebate to the physician so that the net cost to the physician equals ASP plus 3 percent, less a Secretary-determined overhead fee. HHS also would be authorized to pay a portion of the entire amount above ASP in the form of a flat fee.

For the first time, the budget would authorize HHS 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. The proposal would require that as a condition of participation in the Part D program, manufacturers engage in negotiations with HHS and supply the department with all data and information necessary to come to an agreement on price. The negotiated price would be indexed to the Consumer Price Index and Part D plan sponsors would be permitted to negotiate additional discounts below the negotiated price.

The budget addresses drug availability by proposing to prohibit "pay-for-delay" agreements between brand and generic pharmaceutical companies. The Federal Trade Commission would be authorized to block companies from entering into such agreements.

The Medicare appeals process would be modified to address the backlog of pending claims. The Office of Medicare Hearings and Appeals and the Departmental Appeals Board Authority would be authorized to use a portion of Recovery Audit Contractor recoveries for administering the recovery audit program. The budget would increase the minimum amount in controversy required for an Administrative Law Judge to adjudicate a claim to match that of Federal Court. In 2015, this amount was $1,460. The budget also would allow HHS to adjudicate appeals through sampling and extrapolation techniques.

The budget includes other Medicare legislative proposals, such as the following:

- Allow HHS to assign Medicare fee-for-service beneficiaries to Federally Qualified Health Centers and Rural Health Clinics that participate in Accountable Care Organizations (ACOs). In a separate proposal, ACOs participating in a two-sided risk model would be permitted to pay beneficiaries for a primary care visit. Beneficiaries without supplemental insurance would have all or part of their cost sharing covered by the ACO. Those with supplemental policies would receive a payment from the ACO. Medicare would not make additional payments to cover the costs;

- Permit non-physician practitioners to document the face-to-face requirement for Durable Medical Equipment claims;

- Reduce Medicare bad debt payments from 65 percent to 25 percent over a three-year period for all providers who receive such payments; and

- Charge new Medicare beneficiaries, beginning in 2019, a $100 copayment per home health episode.

The budget also includes a number of ACA provisions that reduce Medicare spending. For example, the budget assumes a value-based purchasing program for skilled nursing facilities will begin in FY 2019. Medicare payment for clinical laboratory tests would be linked to private sector payment rates.

The budget includes an ACA provision that revises the End State Renal Disease prospective payment system by delaying the date that oral-only drugs are included in the payment bundle from CY 2016 to CY 2023.

The budget also notes that the ACA expands the list of criteria that HHS can use to identify potentially mis-valued services in the physician fee schedule.

For More Information

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**AHLA Connections* and *Modern Healthcare*, (June 2014).

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* Law360, March 2014
** *The American Lawyer* 2013 and 2014 reports

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