Centers for Medicare & Medicaid Services: President's FY2013 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, such as Medicare benefits, such changes are generally included in the budget. President Obama submitted his FY2013 budget to Congress on February 13, 2012.

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 Children's Health Insurance Program (CHIP), among other activities. The President's budget estimates CMS's net mandatory and discretionary outlays will be $829.4 billion in FY2013, which is an increase of $72.3 billion, or 9.5%, over the net outlays for FY2012. This estimate includes a Medicare physician payment adjustment, the estimated impact of the legislative proposals, and the estimated savings from program integrity investments.

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 FY2013 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.

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, and health insurance programs. At the end of each of these sections, there is a table summarizing the estimated costs or savings for each legislative proposal.

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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. President Obama submitted his FY2013 budget to Congress on February 13, 2012.

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 Children's Health Insurance Program (CHIP) among other activities. The President's FY2013 budget includes a number of assumptions and proposed legislative changes to CMS programs and activities.

The discussion below provides an overview of the President's FY2013 budget for CMS. The discussion begins with the FY2013 budget baseline (i.e., an estimate of spending under current laws and current policy) for CMS and explains how much the President's budget amends the baseline through assumptions and legislative proposals to arrive at the President's FY2013 budget for CMS.

The President's budget estimates that under *current law* CMS mandatory and discretionary net outlays would amount to $809.0 billion in FY2013.[2] This is an increase of $61.3 billion, or 11.7%, over the estimated net outlays for FY2012.

The President's FY2013 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 $9.2 billion in FY2012 and $25.6 billion in FY2013. With this adjustment, CMS's total net outlays are estimated to be $834.6 billion in FY2013.

The President's FY2013 budget proposes to make a number of legislative changes to Medicare, Medicaid, program management, and health insurance programs. The President's budget estimates that if these legislative proposals were implemented, CMS's total net outlays would increase by $0.6 billion in FY2012 and decrease by $4.6 billion in FY2013.

With the Medicare physician payment adjustment, the estimated impact of the legislative proposals, and the estimated savings from program integrity investments ($0.6 billion), the President's budget estimates CMS's net outlays will be $829.4 billion in FY2013, which is an increase of $72.3 billion, or 9.5%, over the net outlays for FY2012.

[1] 31 U.S.C. 1105(a).

[2] The figures in this document come from the following two documents: Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf and Department of Health and Human Services' Centers for Medicare & Medicaid Services, *Fiscal Year 2013 Justification of Estimates for Appropriations Committees.*

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, and health insurance programs. At the end of each of these sections, there is a table summarizing the estimated costs or savings for each legislative proposal.

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 Summaries

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

Medicare

Medicare is a federal insurance 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.[3]

The President's FY2013 budget estimates that under current law Medicare outlays net of offsetting receipts will be $510.4 billion in FY2013 (see **Table 1**). The President's budget makes adjustments to the baseline assuming Congressional action preventing a reduction in Medicare physician payments, which increases the FY2013 baseline outlays net offsetting receipts by $25.6 billion. The budget includes a number of legislative proposals for Medicare. If implemented,

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

these legislative proposals are estimated to decrease Medicare outlays by $4.8 billion during FY2013.[4] With the baseline adjustments and the estimated impact of the legislative proposals, the President's budget estimates that total net mandatory and discretionary outlays for FY2013 will be $531.3 billion, which is an increase of $44.9 billion, or 9.2%, over the estimated net outlays for FY2012.

The President's FY2013 budget eliminates the sequestration process (i.e., the automatic spending reduction process) specified in the Budget Control Act (P.L. 112-25).[5] [6] The Congressional Budget Office (CBO) estimates that sequestration would produce $88 billion in net saving for the Medicare program through a 2% reduction in payment rates for most Medicare services from February 2013 and January 2022.[7]

The "Medicare" 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.

Table 1. President's FY2013 Budget for the Centers for Medicare & Medicaid Services

(dollars in billions)

				FY2012-FY2013	
	FY2011	FY2012	FY2013	$ Change	% Change
Medicare					
Current Law	485.9	476.7	510.4	33.8	7.1%
Adjustments	0.0	9.2	25.6		
Legislative Proposals Net Offsetting Receipts[a]	0.0	0.5	-4.8		
Subtotal	485.9	486.4	531.3	44.9	9.2%
Medicaid					
Current Law	275.0	255.1	282.7	27.6	10.8%
Legislative Proposals	0.0	0.2	0.2		
Subtotal	275.0	255.3	282.9	27.6	10.8%
CHIP					
Current Law	8.6	9.9	10.2	0.3	3.3%
State Grants and Demonstrations					
Current Law	0.6	0.6	0.5	-0.1	-21.5%

[4] The $4.8 billion in savings is comprised of a net cost of $1.3 billion for legislative proposals and $6.1 billion in savings from premiums and offsetting receipts.

[5] Congressional Budget Office, *An Analysis of the President's 2013 Budget*, March 2012.

[6] For more information about the Budget Control Act, see CRS Report R41965, *The Budget Control Act of 2011*, by (name redacted), (name redacted), and (name redacted). For more information about the impact of sequestration on Medicare, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by (name redacted).

[7] Congressional Budget Office, *An Analysis of the President's 2013 Budget*, March 2012.

				FY2012-FY2013	
	FY2011	**FY2012**	**FY2013**	**$ Change**	**% Change**
Private Health Insurance Protections and Programs					
Current Law	3.4	4.6	4.1	-0.6	-12.6%
Legislative Proposals	0.0	0.0	0.0		
Subtotal	3.4	4.6	4.1	-0.6	-12.6%
CMMI					
Current Law	0.0	0.7	1.1	0.4	48.7%
Savings from Program Integrity[b]	0.0	-0.4	-0.6		
Total Net Outlays, Proposed Law	**773.5**	**757.1**	**829.4**	**72.3**	**9.5%**

Source: Table created by CRS based on data from the Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

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

CHIP: Children's Health Insurance Program.

CMMI: Center for Medicare and Medicaid Innovation.

a. The FY2013 figure includes $100 million in legislative proposals for program management activities.

b. These figures include program integrity savings from current law and legislative proposals. FY2012 and FY2013 include $1.0 billion and $1.4 billion respectively in non-PAYGO Scorecard savings from increased Health Care Fraud and Abuse Control (HCFAC) investment and Social Security Disability reviews. A portion of these savings is assumed in current law. The President's Budget proposes to increase the 2012 HCFAC discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with the Budget Control Act of 2011.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care.[8] 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 require coverage for individuals under the age of 65 with income up to 133% of the federal poverty level.[9] The federal government pays a share of each state's Medicaid costs; states must contribute the remaining portion in order to qualify for federal funds.[10]

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

[9] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) establishes 133% of federal poverty level (FPL) based on modified adjusted gross income (MAGI) as the new mandatory minimum Medicaid income eligibility level. The law also specifies that an income disregard in the amount of 5% FPL will be deducted from an individual's income when determining Medicaid eligibility based on MAGI, thus the effective upper income eligibility (continued...)

The President's FY2013 budget estimates that under current law Medicaid total net outlays will amount to $282.7 billion, which is an increase of $27.6 billion, or 10.8%, over estimated net outlays for FY2012 (see **Table 1**).[11] 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 increase by $0.2 billion in FY2013. Including the estimated impact of the legislative proposals and savings from program integrity investments, the President's budget estimates FY2013 total net outlays for Medicaid will amount to $282.9 billion, which is an increase of $27.6 billion, or 10.8%, over the estimated net outlays for FY2012.

The "Medicaid" section below includes a brief discussion of current and proposed law for each of the program proposals. At the end of the section, there is a table summarizing the costs or savings for each of the President's legislative proposals.

CHIP

The Balanced Budget Act of 1997 (P.L. 105-33) established the State Children's Health Insurance Program (CHIP) to provide health care 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 Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) 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 FY2013 budget estimates that under current law CHIP's total outlays will amount to $10.2 billion, which is an increase of $0.3 billion, or 3.3%, over the estimated outlays for FY2012 (see **Table 1**).[12] While there are no specific CHIP legislative proposals, proposals in other parts of the CMS budget will have an impact on CHIP, including (1) the proposal to create a

(...continued)

threshold for such individuals in this new eligibility group will be 138% FPL. On November 21, 2011, President Obama signed into law P.L. 112-56, which will change the definition of income to include non-taxable Social Security in the definition of MAGI.

[10] For more information about the federal share of Medicaid expenditures, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by (name redacted) and (name redacted). For a broader overview of financing issues, see archived CRS Report RS22849, *Medicaid Financing*, by (name redacted).

[11] 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 $27.7 billion, or 11.5%, in FY2013, and outlays for state administration are estimated to decrease by $0.2 billion, or 1.0%, in FY2013.

[12] 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 $0.2 billion, or 2.5%, from FY2012 to FY2013, and the Child Enrollment Contingency Fund outlays are estimated to increase by $0.1 billion, or 60%, from FY2012 to FY2013.

single blended matching rate, and (2) the proposal to prevent the use of federal funds to pay a state's share of Medicaid or CHIP. These proposals are discussed the "Medicaid" legislative section of this report, and the program integrity section, respectively.

Program Integrity

Title II of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) established the Health Care Fraud and Abuse Control (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 in Medicare Advantage and Medicare Part D among other things. Additionally, the Medicaid Integrity Program works 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 FY2013 budget estimates total budget authority for program integrity activities will amount to $1.9 billion in FY2013. This is an increase of $36 million, or 1.9%, over FY2012. Funding for program integrity consists of both mandatory and discretionary funding. In FY2013, the mandatory funding for program integrity activities is estimated to be $1.3 billion, and the discretionary funding is estimated to be $0.6 billion.

The "Program Integrity" 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 programs: Money Follows the Person Demonstration, Medicaid Integrity Program, Medicaid Emergency Psychiatric Demonstration, Incentives for Prevention of Chronic Diseases in Medicaid, CHIP Outreach and Enrollment Grants, and emergency services for undocumented aliens. The President's FY2013 budget estimates that under current law FY2013 total outlays for state grants and demonstrations will amount to $0.5 billion, which is a decrease of $0.1 billion, or 21.5%, from FY2012 (see **Table 1**). The President's budget does not include any legislative proposals pertaining to the state grants and demonstrations portion of the CMS budget.

Private Health Insurance Protections and Programs

The Affordable Care Act includes reforms of the health insurance market that focus on restructuring the private health insurance market by creating new programs and by imposing requirements on private health insurance plans.[13] Certain reforms require the participation of

[13] For more information about the ACA requirements related to the private health insurance market, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

public agencies and 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.[14] The President's FY2013 budget proposal includes estimates of the effects of ACA provisions that are currently in effect and includes one legislative proposal related to the private health insurance market.

The President's FY2013 budget estimates that under current law FY2013 total outlays for the health insurance programs will amount to $4.1 billion, which is a decrease of $0.6 billion, or 12.6%, from FY2012 (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 Protections and Programs" section below includes a description of current and proposed law for the President's legislative proposal.

Center for Medicare and Medicaid Innovation (CMMI)

CMMI was established by Section 3021 of 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. ACA appropriated $10 billion to support CMMI activities from FY2011 to FY2019. The President's FY2013 budget estimates that under current law FY2013 total outlays for CMMI will amount to $1.1 billion, which is an increase of $0.4 billion, or 48.7%, from FY2012 (see **Table 1**). The President's budget does not include any legislative proposals impacting CMMI.

Medicare Quality Improvement Organizations (QIOs)

The Quality Improvement Organization (QIO) 10th Statement of Work (SOW) began August 1, 2011, and will end July 13, 2014. FY2012 is the first full year the 10th SOW will be operational. There is $827.0 million authorized to support the 10th SOW during FY2012. An estimated $528.0 million is necessary to successfully fund the QIO SOW during FY2012. Starting in FY2012, CMS will pay for staff working on QIO activities out of the QIO account instead of the Program Management account.

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 FY2013 budget estimates total program level funding for program management activities will amount to $5.6 billion in FY2013. This is an increase of $1.0 billion, or 20.3%, over FY2012.[15]

[14] For information about CCIIO, see http://cciio.cms.gov/.

[15] The President's FY2013 budget estimate for CMS's program management activities includes an adjustment for reimbursable administration that amounts to $0.5 billion in FY2013. This reimbursable administration adjustment includes Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, MA/prescription drug program education campaign, recovery audit contractors, (continued...)

Funding for program management consists of both discretionary and mandatory funding. The discretionary funding for program management activities is estimated to be $4.8 billion, which is an increase of $1.0 billion, or 71%, over FY2012 funding.[16] 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. Generally, this increased funding is included in the program operations budget line, which increases to $3.6 billion ($1.0 billion more than the net outlays for FY2012). Approximately $24.6 million of the program operations increase can be attributed to a shift of research activities into the program operations line. Starting in FY2012, the research funding line is no longer separately identified, because the program has been integrated into CMMI.

In FY2013, under current law, the mandatory funding for program management activities is estimated to be $0.3 billion, which is a $35 million decrease from the FY2012 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 FY2013. The legislative proposals impacting program management are discussed in other sections 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 $6.0 billion in FY2013. This is an increase of $1.4 billion, or 28.9%, over FY2012.

Legislative Proposals

The President's FY2013 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, and private health insurance protections and programs. At the end of each of these sections there is a table summarizing the costs or savings for each legislative proposal.

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and provider enrollment fees.

[16] The $1.0 billion increase in discretionary funding is the net of both increases and decreases. Approximately $5.5 million of this increase consists of increased costs for activities that are currently funded, such as a 0.5% FY2013 salary increase that has been requested, an additional day of pay included in FY2013, and rent or mortgage costs increases. Also, there is an increase of $1,255 million for new program activities, such as a $26.5 million increase for 136 additional full-time-equivalents (FTEs) which would be reflected in the Federal Administration budget line. These increases are offset by $255 million in program decreases. An additional 120 FTEs would be funded through other funding sources including HCFAC, state grants, fees and mandatory appropriations.

Common Acronyms for Public Laws

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

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

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

BIPA: The Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554)

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

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

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

Medicare

Physician Payments (Adjustment to Baseline)[17]

Current Law

Medicare payments for Part B services provided by physicians and certain non-physician practitioners are made on the basis of a fee schedule, comprised of a list of over 7,000 tasks and services for which physicians bill Medicare. Introduced as part of BBA97, the Sustainable Growth Rate (SGR) is the statutory method for determining the annual updates to the Medicare physician fee schedule. In the first few years of the SGR system the actual expenditures did not exceed set targets and the updates to the physician fee schedule were close to, or exceeded, the Medicare economic index (MEI, a price index of inputs required to produce physician services). However, each year since 2002, actual expenditures have exceeded allowed targets, resulting in a series of ever-larger cuts under the formula. With the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions.

Adjustment to the Baseline

The President's budget includes an adjustment to its baseline that would not allow payments to physicians to be reduced because actual expenditures have exceeded targets. The adjustment to the baseline reflects the Administration's best estimate of continuing what Congress has done in recent years for physician payments (i.e., freezing payments at current levels).[18]

[17] The President's budget includes an adjustment to its baseline of $429 billion over 10 years to reflect the Administration's best estimate of the cost of future Congressional action, based on what Congress has done in the past. This cost is not reflected in the legislative proposals; rather, it is an adjustment to the baseline.

[18] For more information, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by (name redacted) and (name redacted).

Medicare Part A

Adjust Payment Updates for Certain Post-Acute Care Providers

Current Law

The Medicare Payment Advisory Commission (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 2011 *Report to Congress*, MedPAC recommended that the Medicare payment updates for skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and home health agencies (HHAs) be eliminated for the upcoming year. MedPAC projected the aggregate Medicare SNF margin (the amount that Medicare payments exceed SNF costs) to be 10.9% in 2011; the aggregate Medicare margin for IRFs to be 8.1% in 2011; the aggregate margin for LTCHs to be 4.8% in 2011; and the aggregate Medicare margin for freestanding HHAs to be 14.5% in 2011. Additionally, 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; the timing of the implementation of the productivity adjustment varies by provider.[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 varies by provider.[20] 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 (IRFs, LTCHs, SNFs, HHAs) of 1.1 percentage points from 2014 through 2021. Payment updates for these providers would not drop below 0.0.

Reduce Medicare Coverage of Bad Debt

Current Law

Medicare reimburses providers for beneficiaries' unpaid coinsurance and deductible amounts after reasonable collection efforts.[21] Historically, Medicare has reimbursed 100% of these bad debts. BBA97 reduced the existing 100% of bad debt reimbursement in acute care hospitals to

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

[20] CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*. See Appendix B for timeline of update reductions for each provider.

[21] The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96), passed by Congress on February 17, 2012, includes a provision to reduce Medicare's payments to providers for beneficiaries' bad debt. Starting in FY2013, providers who are reimbursed at 70% would be reduced to 65% reimbursement; providers who are reimbursed at 100% would be phased-down to 65% reimbursement over three years.

75% reimbursement in 1998; to 60% reimbursement in 1999 and to 55% reimbursement in subsequent years. BIPA froze the reduction at 70% reimbursement in FY2001 and for subsequent years. DRA reduced the payment amount for Medicare-allowable SNF bad debt from 100% to 70%, except for the bad debt attributable to beneficiaries eligible for both Medicare and Medicaid (dual eligibles), effective for cost reporting periods beginning on or after October 1, 2005. For other Medicare providers, allowable beneficiary bad debt is reimbursed at 100%. Specifically, Medicare reimburses 100% of beneficiaries' allowable bad debt in critical access hospitals, rural health clinics, federally qualified health clinics, community mental health clinics, health maintenance organizations reimbursed on a cost basis, competitive medical plans, and health care prepayment plans. Medicare also reimburses end stage renal disease (ESRD) facilities 100% of allowable bad debt; this does not include bad debts for covered ESRD services paid under a reasonable charge-based methodology or fee schedule.

President's Proposal

The President's budget would reduce bad debt reimbursement to 25% over three years for all providers who receive bad debt payments, starting in 2013.

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. 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 Health and Human Services set standards for receiving such funds.

President's Proposal

The President's budget would reduce IME funding by a total of 10%, starting in 2014. 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.

Encourage Appropriate Use of Inpatient Rehabilitation Facilities (IRFs)

Current Law

IRFs are either freestanding hospitals or distinct part units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS) 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 in 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%; comorbidities are included as qualifying conditions. It also continued the use of secondary conditions to establish a patient's qualifying conditions.

President's Proposal

The President's budget would reinstitute the 75% threshold, starting in 2013.

Equalize Payments for Certain Conditions Commonly Treated in IRFs and SNFs

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 a SNF and an IRF. 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 conditions that overlap. Beginning in 2013, the proposal would limit payment differentials for three conditions involving hips and knees as well as additional conditions the Secretary considers applicable.

Adjust SNF Payment to Reduce Hospital Readmissions

Current Law

As established by ACA, acute care hospitals with relatively high readmission rates will be subject to penalties starting in FY2013. The penalties are capped at 1% 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 March 2010, MedPAC recommended that Congress establish a quality incentive payment policy for SNFs in Medicare and suggested that using measures such as rehospitalization rates would encourage provides to improve care coordination across different health care settings.

President's Proposal

The President's budget would reduce payments to skilled nursing facilities with high rates of preventable hospital readmissions by up to 3% beginning in 2016.

Reduce Critical Access Hospital Reimbursement 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 most hospitals receive under the hospital prospective payment system. Since 2004, 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 2013.

Prohibit CAH Designation for Facilities Less Than 10 Miles from 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.

Medicare Parts A and B

Introduce Home Health Copayments for New Beneficiaries

Current Law

Home Health Agencies (HHAs) are paid under a prospective payment system. Payment is allowed for a 60-day episode of care for beneficiaries, subject to several adjustments. The 60-day episode covers skilled nursing, therapy, medical social services, and aide visits as well as medical supplies. Generally, Medicare beneficiaries do not have a copayment for home health services and supplies; there are copayments for Medicare-covered durable medical equipment and osteoporosis drugs provided during a home health episode of care. In March 2011, 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

The President's budget would institute a $100 copayment for each home health 60-day episode with 5 or more visits beginning in 2017.

Medicare Part B

Update Medicare Payments to More Appropriately Account for Utilization in Advanced Imaging

Current Law

Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. For example, imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component). Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

CMS's original method for calculating the Medicare fee schedule reimbursement rate for the technical component of advanced imaging services assumed that imaging machines are operated 25 hours per week, or 50% of the time that practices are open for business. Setting the equipment use factor at a lower rate has led to higher per unit payment for these services since the cost of the equipment is spread over fewer procedures. Citing evidence showing that the utilization rate is 90%, rather than the 50% previously assumed, MedPAC recommended that CMS use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services and CMS adopted a 90% use rate assumption in its 2010 final rule (published on November 25, 2009) for Medicare physician payment. Provisions in the ACA countermanded the CMS final rule and changed the utilization rate assumption for calculating the payment for advanced imaging equipment from 50%, as assumed in prior years, to 75% for 2011 and in subsequent years.

President's Proposal

Beginning in 2013, this provision would implement a payment reduction for advanced imaging equipment by assuming an increase in the use rate from 75% to 90%.

Introduce Part B Premium Surcharge for New Beneficiaries Purchasing 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 2017, the proposal 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. This is equivalent to about 30% of the Part B premium.

Modify Part B Deductible for New Beneficiaries

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. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) 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).[22] The deductible was $155 per year in 2010, $162 in 2011, and $140 in 2012.

[22] Methodology and updates for 2012 detailed in 76 *Federal Register* 67572, November 11, 2011, http://www.gpo.gov/ (continued...)

President's Proposal

The proposal would increase the annual deductible by an additional $25 in 2017, 2019, and 2021 for new Medicare enrollees.

Medicare Parts B and D

Increase Income-Related Premiums Under Parts B and 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 (enrollees who were 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.) ACA also imposed a similar income-related premium for Part D services. In addition, 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 2017, this 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.

Medicare Part D

Align Medicare Drug Payments 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. Medicare beneficiaries who qualify for Medicaid based on their income and assets (dual-eligibles), are recipients of Medicare Savings Programs, or who

(...continued)
fdsys/pkg/FR-2011-11-01/pdf/2011-28186.pdf.

receive Supplemental Security Income are automatically eligible for the full low-income subsidy. Others who do not qualify for one of the above, but whose incomes are below 150% of poverty may also be eligible for the low-income subsidy and receive assistance for some portion of their premium and cost sharing charges. About 40% of Part D enrollees receive the low-income subsidy.

Prescription drug coverage is provided through private prescription drug plans (PDPs), which offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA-PDs) which offer prescription drug coverage that is integrated with the health coverage provided under Part C. The plans are paid a monthly per capita amount based on their estimate of the cost of benefits in a given plan year. Part D plan sponsors determine payments for drugs and are expected to negotiate prices with drug manufacturers. These negotiations may involve an agreement from the manufacturer to provide a rebate in exchange for the inclusion of a drug on a plan's formulary and/or for placement in a "preferred" drug category that has lower beneficiary cost sharing. (The federal government is prohibited from interfering in these negotiations.)

Prior to the implementation of the Medicare Part D drug benefit in 2006, Medicaid was the primary payer for drugs for full-benefit dual-eligible beneficiaries. Drug manufacturers who wish to have their drugs available for Medicaid enrollees must provide state Medicaid programs with rebates on drugs paid for on behalf of Medicaid beneficiaries. For the purpose of determining 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 there now are generic equivalents), and (2) all other, non-innovator, multiple source drugs. Medicaid's basic rebate is 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.[23]

President's Proposal

Beginning in 2013, this proposal 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 low-income subsidy beneficiaries.

Administrative Proposals

Dedicate Penalties for Failure to Use Electronic Health Records (EHRs) Toward Deficit Reduction

Current Law

The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) requires that in FY2020 and in each subsequent year, the amount of the penalties imposed on Medicare providers

[23] 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.

for not meeting the "meaningful use" criteria for electronic health records (EHR) are to be made available to the Medicare Improvement Fund (MIF). The MIF was established under Section 188 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), and the funds are to be available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries.

President's Proposal

The amount of the penalties would be redirected towards deficit reduction.

Strengthen IPAB to Reduce Long-Term Care Drivers of Medicare Cost Growth

Current Law

ACA establishes an Independent Payment Advisory Board 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.

President's Proposal

Beginning in the sixth year of implementation, 2020 (which ties to the 2018 determination year) when the target growth rate is based on the growth in nominal GDP per capita, the proposal would lower the target growth to the growth rate in nominal GDP per capita plus 0.5 percentage point. The IPAB would also be given "additional tools like the ability to consider value-based benefit design and policies that promote integrated and coordinated care."

Other

Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics

Current Law

P.L. 98-417, the Drug Price Competition and Patent Term Restoration Act of 1984 (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.

Amendments to the original Hatch-Waxman Act contained in P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, include two provisions that affect "pay-for-delay" arrangements. Settlement agreements must, in many cases, be filed with the Federal Trade Commission (FTC) and the Department of Justice to allow review of the settlements for possible anticompetitive effects. In addition, P.L. 108-173 stipulates certain events that would cause the first generic challenger(s) to forfeit the 180-day exclusivity.

President's Proposal

Beginning in 2013, the FTC 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."

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics

Current Law

The Biologics Price Competition and Innovation Act (BPCIA) of 2009, incorporated into Title VII of the Patient Protection and Affordable Care Act (P.L. 111-148), 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, BPCIA provides for a term of marketing exclusivity for the applicant that is the first to establish its product is interchangeable with the brand-name biologic. Finally, BPCIA creates a patent dispute resolution procedure for use by brand-name and follow-on biologic manufacturers.

President's Proposal

Effective in 2013, brand biologics would be awarded seven years of exclusivity rather than the current 12 years and there would be no additional exclusivity periods for "minor" changes in product formulations.

Extend the Qualified Individual (QI) Program through CY2014

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 the Federal Poverty Limit. BBA97 also amended the Social Security Act (SSA) 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 382,200 QI individuals in FY2010. Since it was first funded in October 1, 1998, the QI program has been extended 12 times. The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) authorized the QI program through December 31, 2012, and appropriated $450 million in FY2012 and $280 million in FY2013.

President's Proposal

The President's budget would extend QI authorization through December 31, 2014. This proposal would authorize an additional calendar year (CY) 2013 appropriation of $695 million (part of the CY2013 appropriation would be for the first quarter of FY2014). The President's budget also would authorize a CY2014 QI appropriation of $995 million (these funds would be applicable to the second through the fourth quarters of FY2014 and the first quarter of FY2015).[24]

Table 2. President's FY2013 Budget Legislative Proposals and Estimated Savings for Medicare

(dollars in millions)

Legislative Proposals	HHS Estimates		
	FY2013	FY2013-FY2017	FY2013-FY2022
Medicare Part A			
Adjust Payment Updates for Certain Post-Acute Care Providers	-30	-10,360	-56,670
Reduce Medicare Coverage of Bad Debt	-770	-12,840	-35,880

[24] The President's FY2013 budget was released prior to the passage of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96). At the time the President's proposal was developed, the QI program was set to expire on February 29, 2012. However, the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) extended the QI program through December 31, 2012. The Administration estimated the cost of this provision prior to the passage of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96). For this reason, the cost of extending the QI program through December 31, 2014, is expected to be lower than the cost listed in **Table 2**.

Legislative Proposals	HHS Estimates		
	FY2013	FY2013-FY2017	FY2013-FY2022
Better Align Graduate Medical Education Payments with Patient Care Costs	0	-3,750	-9,690
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	-180	-1,050	-2,300
Equalize Payments for Certain Conditions Commonly Treated in IRFs and SNFs	-140	-850	-2,010
Adjust SNF Payment to Reduce Hospital Readmissions	0	-460	-1,950
Reduce CAH Reimbursement to 100% of Costs	-70	-570	-1,420
Prohibit CAH Designation for Facilities Less Than 10 Miles from Nearest Hospital	0	-220	-590
Medicare Parts A and B			
Introduce Home Health Copayments for New Beneficiaries	0	-10	-350
Medicare Part B			
Update Medicare Payments to More Appropriately Account for Utilization in Advanced Imaging	-40	-330	-820
Introduce Part B Premium Surcharge for New Beneficiaries Purchasing Near First Dollar Medigap Coverage	0	-80	-2,530
Modify Part B Deductible for New Beneficiaries	0	0	-1,990
Medicare Parts B and D			
Increase Income-Related Premiums Under Parts B and D	0	-1,430	-2,7571
Medicare Part D			
Align Medicare Drug Payments with Medicaid Policies for Low-Income Beneficiaries	-3,796	-48,770	-155,553
Administrative Proposals			
Dedicate Penalties for Failure to Use EHRs Toward Deficit Reduction	0	0	-590
Strengthen IPAB to Reduce Long-Term Care Drivers of Medicare Cost Growth	0	0	0
Other			
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics	-545	-3,373	-8,610
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics	-19	-627	-3,655
Extend the Qualified Individual (QI) Program through CY2014	695	1,690	1,690
Interactions (for savings realized through IPAB and other interactions)	-2	268	8,112
Reduce Fraud, Waste, and Abuse in Medicare	-10	-130	-450
Total Proposals Impacting Medicare	**-4,907**	**-82,892**	**-302,827**

Source: Table created by CRS based on information in the Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

Notes: IRF: Inpatient Rehabilitation Facility**, SNF:** Skilled Nursing Facility**, CAH:** Critical Access Hospital**, EHR:** Electronic Health Records; totals may not add due to rounding.

Medicaid

Medicaid Financing

Apply a Single Blended Matching Rate to Medicaid and CHIP Starting in 2017

Current Law

Medicaid and the State Children's Health Insurance Program (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.[25] 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%.[26] 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.[27]

During periods of economic downturns, state Medicaid and CHIP programs face dual pressures of increased enrollment and declining state revenues. During the last two recessions, Congress provided temporary increases to Medicaid FMAP rates to help mitigate this pressure on states.[28,29]

President's Proposal

The President's budget proposes to replace the current patchwork of federal matching rates for Medicaid and CHIP with a single federal matching rate for both programs. In addition, the proposal would add an automatic trigger to increase federal matching support of Medicaid and CHIP when a recession causes Medicaid and CHIP enrollment and expenditures to rise.

[25] For FY2013, regular FMAP rates range from 50.00% to 74.43%.

[26] For FY2013, regular FMAP rates range from 65.00% to 81.40%.

[27] 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).

[28] The temporary FMAP rate increases was provided through the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27) and the American Recovery and Reinvestment Act of 2009 (P.L. 111-5). For more information about FMAP, FMAP exceptions, state fiscal conditions, and the temporary FMAP increases, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by (name redacted) and (name redacted).

[29] U.S. Government Accountability Office, *Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns*, GAO-12-38, November 2011.

Phase Down Medicaid Provider Tax Threshold Beginning in FY2015

Current Law

States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers. In order for states to be able to draw down federal Medicaid matching funds, the provider tax must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax applies to all providers within a specified class of providers). Also, states are not allowed to hold the providers harmless for the cost of the provider tax (i.e., they can not guarantee that providers receive some or all of their money back). However, regulations specify an exception to the hold harmless rule if the tax imposed is 6% or less of a provider's net patient revenues. This 6% limit is referred to as the Medicaid provider tax threshold.[30]

President's Proposal

The President's budget includes a provision that phases down the Medicaid provider tax threshold from the current level of 6.0% to 3.5% by FY2017. Specifically, the provider tax threshold would remain at 6.0% through FY2014, then the threshold would decrease to 4.5% in FY2015, 4.0% in FY2016, and 3.5% in FY2017 and subsequent years.

Medicaid Payments

Rebase Medicaid Disproportionate Share Hospital (DSH) Allotments in FY2021

Current Law

Under federal law, states are required to make Medicaid disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income and Medicaid patients. 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 the Consumer Price Index for All Urban Consumers (CPI-U). In FY2011, preliminary federal Medicaid DSH allotments to states totaled $11.3 billion. ACA requires the Secretary to make aggregate reductions in Medicaid DSH allotments 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 Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) applies the $4.0 billion reduction from FY2020 to FY2021.

[30] For more information about Medicaid provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*, by (name r edacted).

President's Proposal

The President's budget proposes to "rebase" the FY2021 Medicaid DSH allotments to the lower FY2020 allotment level increased by the percentage change in CPI-U. The allotments for each subsequent year would be the previous year's allotment level increased by the percentage change in CPI-U.[31]

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 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 upper payment limit currently applies to durable medical equipment (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. Recently enacted legislation established a Medicare competitive acquisition program (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 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.

[31] The President's FY2013 budget was released prior to the passage of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96). At the time the President's proposal was developed, in FY2021, the federal Medicaid DSH allotments would have reverted to FY2013 allotment levels increased by the percentage change in the CPI-U. However, the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) applies the $4.0 billion DSH reduction from FY2020 to FY2021. The Administration estimated the savings for this provision prior to the passage of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96). For this reason, the estimated savings for this provision would be smaller than the savings listed in **Table 3**.

Medicaid Benefits

Expand State Flexibility to Provide Benchmark Benefit Packages

Current Law

Beginning in 2014, states are required to provide Medicaid coverage to certain nonelderly, nonpregnant individuals (e.g., childless adults, parents, and persons with disabilities) with income up to 133% FPL (plus a 5% income disregard) who are otherwise ineligible for this program. When certain conditions are met, states have the option to cover this new Medicaid group prior to 2014.

Also beginning in 2014, states may provide Medicaid coverage to the same types of individuals but with income above 133% FPL (up to a maximum level specified by the state). When certain conditions are met, states may choose to phase in coverage of such individuals over time.

As an alternative to traditional Medicaid benefits, the DRA, as amended, gave states the option to provide Medicaid to state-specific groups through enrollment in benchmark and benchmark-equivalent plans similar to coverage available under CHIP. Benchmark coverage includes (1) the Blue Cross/Blue Shield standard plan option under the Federal Employees Health Benefits Program (FEHBP), (2) coverage generally available to state employees, (3) coverage offered by the largest commercial HMO in the state, or (4) Secretary-approved coverage appropriate for the target population. The law provides for exemptions to mandatory enrollment in such plans for certain subgroups (e.g., those with special health care needs).

President's Proposal

The President's Budget proposes to allow states to require benchmark benefit plan coverage for the optional eligibility group of non-elderly, non-disabled adults with income above 133% FPL. This proposal would be effective in FY2013.

Medicaid Coverage

Extend Transitional Medical Assistance (TMA) through CY2013

Current Law

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).[32] Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to (1) increased child or spousal support 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

[32] See archived CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by (name redacted).

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 6-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 Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) extended the expanded TMA requirements through December 31, 2012.

President's Proposal

The President's budget would extend expanded TMA requirements through December 31, 2013.[33]

Establish Hold Harmless for Federal Poverty Guideline

Current Law

The HHS poverty guidelines 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 (BLS). After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The 2012 poverty guidelines reflect actual price changes between calendar years 2010 and 2011.

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 [SNAP], Women, Infants and Children [WIC], etc.).

[33] The President's FY2013 budget was released prior to the passage of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96). At the time the President's proposal was developed, the expanded TMA requirements were set to expire on February 29, 2012. However, the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) extended the expanded TMA requirements through December 31, 2012. The Administration estimated the cost of this provision prior to the passage of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96). For this reason, the cost of extending the expanded TMA requirements through December 31, 2013, is expected to be lower than the cost listed in **Table 3**.

Table 3. President's FY2013 Budget Legislative Proposals and Estimated Savings for Medicaid

(dollars in millions)

Legislative Proposals	HHS Estimates		
	FY2013	FY2013-FY2017	FY2013-FY2022
Medicaid Financing			
Apply a Single Blended Matching Rate to Medicaid and CHIP Starting in 2017	0	-3,400	-17,900
Phase Down Medicaid Provider Tax Threshold Beginning in FY2015	0	-6,200	-21,800
Medicaid Payments			
Rebase Medicaid Disproportionate Share Hospital (DSH) Allotments in FY2021	0	0	-8,250
Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates	-180	-1,190	-2,950
Medicaid Benefits			
Expand State Flexibility to Provide Benchmark Benefit Packages	0	0	0
Medicaid Coverage			
Extend Transitional Medical Assistance (TMA) through CY2013	640	815	815
Establish Hold Harmless for Federal Poverty Guideline	0	0	0
Total Medicaid Proposals	**460**	**-9,975**	**-50,085**
Savings from Program Integrity Proposals	-151	-1,286	-3,167
Medicaid Interactions with Legislative Proposals in Other Parts of the Budget[a]	-119	-948	-2,448
Total Proposals Impacting Medicaid	**190**	**-12,209**	**-55,700**

Source: Table created by CRS based on data in the Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

Notes: CHIP: Children's Health Insurance Program; totals may not add due to rounding.

a. There is Medicaid budget interaction with a legislative proposal for the Social Security Administration, which proposes to extend Supplemental Security Income time limits for qualified refugees. Also, there is Medicaid budget interaction with a legislative proposal in the Administration for Children and Families, which proposes to eliminate Medicaid recoupment of birthing costs from child support. Medicaid's budget is also impacted by two multi-agency legislative proposals, which propose to modify length of exclusivity to facilitate faster development of generic biologics and to prohibit brand and generic drug companies from delaying the availability of new generic drugs and biologics.

Program Integrity

Medicare

Require Prepayment or Earlier Review for Power Mobility Devices

Current Law

Under current law, Medicare covers durable medical equipment (DME), including power wheelchairs and other power mobility devices (PMDs), when it is determined to be medically necessary.[34] 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.[35] 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.[36] Medicare's FY2010 expenditures for PMDs in these 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 June 1, 2012, and CMS revised the original scope.[37]

President's Proposal

The President's budget proposal would continue the Medicare PMD prior-authorization demonstration.

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

[34] 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).

[35] 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).

[36] The seven states included in CMS's prior authorization demonstration for power mobility devices are California, Illinois, Michigan, New York, North Carolina, Florida, and Texas.

[37] See Paperwork Reduction Act Notice, 77 *Federal Register*, 6123-6125 (February 7, 2012).

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.

Allow 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 nor require 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.

Many providers and health systems are implementing electronic health records (EHR) systems. Provisions in ARRA and ACA provided financial incentives to providers to invest in EHR.[38] Many EHR systems either are linked or have the capability to interact with clinical decision support systems (CDSS) and electronic claims processing. Electronic patient records would contain information on what services practitioners ordered, whereas claims processing systems would 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.

In the meantime, demonstrations could be conducted to identify appropriate data and edits to electronic claims systems that could be used to validate that a service or treatment was ordered by a participating federal health program provider. 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.

[38] For more information on the American Recovery and Reinvestment Act of 2009, see CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*, coordinated by (name redacted) and CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*, coordinated by (name redacted). For more information on Electronic Health Records, see CRS Report RL32858, *Health Information Technology: Promoting Electronic Connectivity in Healthcare*, by (name redacted).

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

Current Law

There are no restrictions 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 accounts in other jurisdictions where it might be difficult for Medicare to recover improper payments to these providers. The Secretary could monitor providers and suppliers use of "sweep" accounts that immediately transfer Medicare provider payments from financial to investment accounts, especially where these accounts are off shore and U.S. banking and other laws might not apply.

Require Prior Authorization for Advanced Imaging

Current Law

According to CMS and MedPAC, imaging service expenditures under the Medicare physician fee schedule grew rapidly between 2003 and 2005. DRA capped the x-ray and imaging services technical component at the lesser rate of the hospital outpatient rate or the physician fee schedule. In addition, CMS's resource-based practice expense methodology has reduced the imaging professional component. ACA set 2010 and 2011 payments for Dual energy X-ray Absorptiometry (DXA) at 70% of 2006 reimbursement rates and required the Institute of Medicine of the National Academies to study and report to the Secretary and Congress on the implications of Medicare DXA reimbursement. Many private health insurance companies already require imaging services to receive prior authorization. Furthermore, the Government Accountability Office (GAO) recommended that CMS consider instituting a prior authorization requirement and other approaches to help control the growth in expensive imaging procedures.

President's Proposal

The President's budget proposes to require that the most expensive imaging services receive prior authorization to ensure that these services are used as intended.

Medicaid

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid

Current Law

Medicaid statutes give 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 physician). 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 that 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 initiate programs to monitor Medicaid claims in order to identify drug 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. State drug monitoring programs would be required to prevent improper prescribing and utilization patterns and to improve Medicaid integrity, without reducing beneficiary quality of care.

Strengthen Medicaid Third-Party Liability (TPL)

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 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 strengthen Medicaid's TPL authority by allowing states to (1) collect 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.

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 (MDR) 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."[39] Rebates paid by manufacturers to Medicaid are calculated based on each manufacturer's average price (AMP) for a drug. AMP is defined in law.[40] 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.

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.

Enforce Manufacturer Compliance with Drug Rebate Requirements

Current Law

CMS has authority to survey drug manufacturers, and the HHS/OIG has authority to audit drug manufacturers. CMS and HHS/OIG monitor Medicaid prescription drug prices submitted by manufacturers and the rebates these companies pay to the Medicaid program (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

[39] See Social Security Act Sec. 1927(d)(2).

[40] CMS recently published a Notice of Proposed Rule Making (NPRM) with guidance for manufacturers and other stakeholders on calculation of average manufacturer price (AMP) and other Medicaid drug rebate issues. For more information, see 77 *Federal Register* 5318 (February 2, 2012).

agreement.[41] Studies have found and False Claims Act settlements have shown irregularities in manufacturers' drug price reporting. ACA made a number of changes to Medicaid prescription drug pricing policies, including provisions to create more uniform manufacturer drug reporting standards.[42]

President's Proposal

The President's budget would require that regular audits and surveys of drug manufacturers be conducted to better ensure manufacturers' compliance with drug rebate agreements, the Medicaid statute, and regulations.

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 Food and Drug Administration (FDA) under the Federal Food Drug and Cosmetics Act (FFDCA). FDA approves drugs when a manufacturer obtains a New Drug Approval (NDA)—generally for sole source brand name drugs—or where a manufacturer obtains an Abbreviated New Drug Application (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. Compendia are reference documents that list how most drugs could be used, both on-label and off-label.[43] Even though current law requires drug manufacturers to list their products with FDA, not all drugs on the market are properly listed. CMS recently published a Notice of Proposed Rule Making (NPRM) that proposed a number of regulatory changes that were authorized by ACA.[44]

President's Proposal

The President's budget would require that drug manufacturers list their products electronically with FDA in order to be covered and reimbursed by Medicaid.

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

[42] CMS published a Notice of Proposed Rule Making (77 *Federal Register* 5318, February 2, 2012) that proposed changes and clarified Medicaid drug price definitions, such as average manufacturer price.

[43] 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).

[44] CMS published a Notice of Proposed Rule Making (77 *Federal Register* 5318, February 2, 2012) that proposed changes and clarified Medicaid drug program definitions, including the requirements that covered drugs be electronically listed with the FDA.

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 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 ACA amended the Medicaid drug rebate statute and CMS recently 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 proposes to specifically increase penalties on drug manufacturers that knowingly report false information under Medicaid drug rebate pricing agreements that are used to calculate Medicaid rebates.

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.[45] 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%.[46] 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.[47] In general, federal regulations prohibit states from using other federal sources to fund the state share of Medicaid, unless authorized by law.

[45] For FY2013, regular FMAP rates range from 50.00% to 74.43%.

[46] For FY2013, regular FMAP rates range from 65.00% to 81.40%.

[47] 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).

President's Proposal

The President's budget would codify in statute the principle that states are prohibited from using federal funds for the state share of Medicaid or CHIP, unless specific exceptions are authorized in law.

Consolidate Redundant Error Rate Measurement Programs

Current Law

The Improper Payments Information Act of 2002 (P.L. 107-300, IPIA) required federal agencies to annually review the programs they oversee that may be susceptible to erroneous payments, to estimate improper payments, and to 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).[48] 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.[49]

President's Proposal

The President's budget would allow the Secretary to consolidate MEQC and PERM requirements.

Medicare and Medicaid

Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse

Current Law

Recovery Audit Contractors (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 (FFS), but expanded the program nationally. Then, under ACA, Congress authorized further expansion of RACs to Medicare Parts C and D and Medicaid. Total FY2010-FY2011 RAC FFS corrections, including overpayment collections and underpayments returned, were $365.8 million, of which $313.2 million were for overpayment collections alone. Under current law, RAC recoveries, net of percentage payments to the four contractors, are returned to the Medicare Trust Fund.[50]

[48] See Social Security Act Sec. 1903(u)(2).

[49] See 75 *Federal Register* 48816 (August 11, 2010).

[50] 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 proposal would authorize CMS to retain a portion of RAC recoveries (up to 25%) from Medicare and Medicaid to be used to fund new processing audits and to fund training to prevent future improper payments.

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

Current Law

The Department of Health and Human Services Office of Inspector General (HHS/OIG) has authority to exclude health care providers (individuals and entities) from participation in federal health care programs. HHS/OIG exclusions authority is mandatory in some circumstances, and permissive in others. 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 Medicare Advantage plans, Medicare prescription drug plans (PDPs) and these organization's providers and suppliers.

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.

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 make it illegal to knowingly distribute Medicare, Medicaid, or CHIP beneficiary identification or billing privileges. This proposal would not affect federal expenditures.

Table 4. President's FY2013 Budget Legislative Proposals and Estimated Savings for Program Integrity Activities

(dollars in millions)

Legislative Proposals	HHS Estimates		
	FY2013	FY2013-FY2017	FY2013-FY2022
Medicare			
Require Prepayment or Earlier Review for Power Mobility Devices	-10	-50	-140
Allow Civil Monetary Penalties for Providers and Suppliers Who Fail to Update Enrollment Records	0	-40	-90
Allow Secretary to Create a System to Validate Practitioners' Orders for Certain High-Risk Items and Services	0	0	0
Increase Scrutiny of Providers Using Higher-risk Banking Arrangements to Receive Medicare Payments	0	0	0
Require Prior Authorization for Advanced Imaging	0	0	0
Medicaid			
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	-40	-620	-1,550
Strengthen Medicaid Third-Party Liability	-110	-630	-1,525
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States	-1	-6	-12
Enforce Manufacturer Compliance with Drug Rebate Requirements	0	0	0
Require Drugs Be Electronically Listed With FDA to Receive Medicaid Coverage	0	0	0
Increase Penalties for Fraudulent Noncompliance on Rebate Agreements	0	0	0
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	0	0	0
Consolidate Redundant Error Rate Measurement Programs	0	0	0
Medicare and Medicaid			
Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse	0	-60	-240
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities	0	-10	-60
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	0	0	0
Total Proposals Impacting Program Integrity	**-161**	**-1,416**	**-3,671**
Savings from Program Integrity Investments[a]	-1,428	-7,014	-15,771
Total Program Integrity Savings	**-1,589**	**-8,430**	**-19,388**

Source: Table created by CRS based on data in the Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

Notes: Totals may not add due to rounding.

a. Includes non-PAYGO Scorecard savings from increased HCFAC investment and Social Security disability reviews. A portion of these savings is assumed in Current Law.

Private Health Insurance Protections and Programs

Accelerate Issuance of State Innovation Waivers

Current Law

Under section 1332 of the ACA, a state may apply to the Secretaries of Health and Human Services 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);
- 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);[51]
- 4980H of the Internal Revenue Code (relating to shared responsibility for employers regarding health coverage);[52]
- And 5000A of the Internal Revenue Code (relating to the requirement to maintain minimum essential coverage).[53]

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.

[51] 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).

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

[53] 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).

Table 5. President's FY2013 Budget Health Insurance Programs Legislative Proposals and Estimated Savings

(dollars in millions)

Legislative Proposals	HHS Estimates		
	FY2013	FY2013-FY2017	FY2013-FY2022
Accelerate Issuance of State Innovation Waivers	0	0	0

Source: Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

CBO's Analysis of the President's FY2013 Budget

Each year, CBO conducts an analysis of the President's budget proposal. Due to differences in economic assumptions and estimates of enrollment, CBO's estimates of the impact of the President's legislative proposals differ from the Administration's estimates that are included in the tables above. The major differences between the CBO and Administration estimates of the legislative proposals affecting CMS are discussed below.

Medicare

The most significant difference between the CBO and Administration estimates for the President's budget proposal regarding CMS involves the response to the statutorily mandated reduction in Medicare payment rates for physicians' services. As mentioned above, the President's budget includes an adjustment to its baseline that would not allow payments to physicians to be reduced as required under current law. CBO estimates that this adjustment would cost $271 billion over the next 10 years,[54] while the Administration estimates that this adjustment would cost $429 billion over the next 10 years.[55] CBO's estimate is significantly lower than the Administration's estimate because of differences in assumptions about the growth in physician spending and corresponding beneficiary premium receipts under the baseline.

CBO estimates that all other Medicare changes proposed in the President's budget, including the legislative proposals for program integrity activities, would reduce Medicare outlays by $276 billion over the next 10 years.[56] CBO's estimate is 9% lower than the Administration's estimate of $303 billion in savings over the next 10 years.[57] Most of the difference between these estimates is due to CBO having lower projections for the indexes used to calculate prices for Medicare providers.[58]

[54] Congressional Budget Office, *An Analysis of the President's 2013 Budget*, March 2012.

[55] Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

[56] Congressional Budget Office, *An Analysis of the President's 2013 Budget*, March 2012.

[57] Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

[58] Congressional Budget Office, *An Analysis of the President's 2013 Budget*, March 2012.

Medicaid

For Medicaid, CBO estimates the legislative proposals in the President's FY2013 budget, including the program integrity activities, would save $66 billion over the next 10 years.[59] This estimate is 12% higher than the Administration's estimated savings of roughly $59 billion.[60]

There are two significant differences between the CBO and Administration estimates of the Medicaid proposals. First, CBO estimates that the proposal to phase down the Medicaid provider tax threshold would save $48 billion over the next 10 years, while the Administration estimates that this proposal would save $22 billion.[61] Second, CBO estimates significantly lower savings for the proposal to rebase Medicaid DSH allotments.[62]

Private Health Insurance Protections and Programs

CBO estimates that the President's proposal to accelerate the issuance of state innovation waivers would result in a net cost of $4.4 billion over the next 10 years.[63] However, the Administration estimates that this proposal would have no budgetary impact.[64]

[59] Congressional Budget Office, *An Analysis of the President's 2013 Budget*, March 2012.

[60] Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

[61] Congressional Budget Office, *CBO Estimate of Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year* 2013, March 16, 2012; Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

[62] Congressional Budget Office, *CBO Estimate of Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year* 2013, March 16, 2012; Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

[63] Congressional Budget Office, *CBO Estimate of Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year* 2013, March 16, 2012.

[64] Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

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