Analyzing the President's FY 2020 Budget: Key HHS Proposals

The White House FY 2020 budget outlines the administration's priorities for the upcoming fiscal year. In the area of health care, the president has requested $87.1 billion in discretionary budget authority for HHS, which represents a 12 percent decrease from the 2019 estimated level. Below we highlight key HHS proposals.

On March 11, 2019, the White House released its FY 2020 budget proposal. The budget outlines the administration's priorities for the upcoming fiscal year. In the area of health care, the president has requested $87.1 billion in discretionary budget authority for the US Department of Health and Human Services (HHS), which represents a 12 percent decrease from the 2019 estimated level. The administration's annual budget should be viewed as a messaging tool, since many of the legislative policies are unlikely to move forward. With a Democrat-controlled House of Representatives, legislative proposals almost certainly will not become law. An exception to that general rule may occur where there are proposals categorized in the budget as legislative but where the Administration has some authority to move forward with regulatory action on the topic. Proposals categorized as regulatory should be monitored closely, however, and could be implemented in some cases.

This week Secretary Azar will defend the budget in three separate hearings. The House Energy and Commerce Health Subcommittee hearing on Tuesday went as expected. Democrats criticized the sizable budget cuts to Medicare and Medicaid, while Republicans focused primarily on the drug pricing provisions. Secretary Azar defended the cuts to Medicaid and Medicare, saying that doing so will protect the longevity of the programs and lower costs for beneficiaries.

Below we have highlighted key proposals from the HHS Budget.

Prescription Drug Pricing

The administration has been active in outlining its agenda to lower prescription drug costs. In May 2018, the administration published the American Patients First Blueprint, which delineated its proposals to reduce drug costs. The budget proposal builds on these concepts as well as proposals in previous budget requests and current administration action relating to prescription drug pricing.

The budget includes no specific regulatory proposals on prescription drug pricing. Instead, it focuses on legislative proposals, including a call to provide the Secretary with authority to consolidate certain drugs currently covered under Medicare Part B into Part D. This measure could allow for increased price competition by leveraging Part D plan negotiating abilities. The budget also would require all drug manufacturers to report from average sales price (ASP) data for Part B drugs, and would provide the Secretary with the authority to apply civil monetary penalties to manufacturers that do not report required data. The budget further proposes to reduce payment for innovator drugs from ASP plus six percent to ASP minus 33 percent when a manufacturer files a pay-for-delay agreement or takes another anti-competitive action after the primary patent or market exclusivity period expires.

The budget proposes to eliminate cost sharing reductions on generics and biosimilars for low-income subsidy Medicare Part D enrollees, and calls for eliminating beneficiary cost sharing above the

catastrophic coverage threshold. The budget also proposes to exclude manufacturer discounts from the calculation of true beneficiary out-of-pocket costs.

As included in last year's proposal, the budget calls for a five-state demonstration to test a closed Medicaid formulary in which Medicaid can negotiate prices directly with drug manufacturers. The proposal would increase the civil monetary penalty paid by drug manufacturers for providing false or late reporting of information to the Medicaid Drug Rebate Program.

The budget also includes 340B-related proposals. These proposals include allowing the Health Resources and Services Administration to collect a 0.1 percent user fee for total 340B drug purchases from participating covered entities, and requiring 340B covered entities to report the savings achieved through the 340B program and how those savings are used. The budget refers to the CY 2018 Outpatient Prospective Payment System regulation that reduced outpatient hospital payment for 340B drugs from ASP plus six percent to ASP minus 22.5 percent. Currently, these dollars must be redistributed across Medicare payments to outpatient hospitals in a budget-neutral way. The proposal would change how this funding is distributed to a non-budget-neutral way, in that hospitals providing at least one percent of patient care costs in uncompensated care will receive redistributed savings based on the percentage of all uncompensated care they provide compared with other outpatient hospitals.

Medicare

The budget includes a number of legislative and regulatory proposals related to Medicare. The president proposes a legislative package expected to result in net savings to the Medicare Trust Fund of $811 billion over 10 years. The proposal includes:

+ Beginning in 2021, creating a risk-adjusted monthly Medicare priority care payment for providers who are eligible to bill for evaluation and management (E/M) services and who provide ongoing primary care to Medicare beneficiaries; the proposal would be funded by a five percent annual reduction to the valuations of all non-E/M services and procedures under the Physician Fee Schedule
+ Expanding the basis for beneficiary assignment for accountable care organizations by allowing the Secretary to base beneficiary assignment on a broader set of primary care providers
+ Reforming the physician self-referral law to align with the movement to alternative payment models (APMs)
+ Reforming the Medicare Access and CHIP Reauthorization Act Merit-based Incentive Payment System and Advanced APM pathways
+ Creating a consolidated hospital quality payment program that combines existing programs, including the Hospital Value-Based Purchasing Program, the Inpatient Quality Reporting Programs, the Hospital-Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program
+ Advancing site neutrality provisions between on-campus hospital outpatient departments and physician offices for certain services, such as clinic visits; eliminating the disparity between what Medicare pays in these settings for the same services; and requiring all off-campus hospital emergency departments to be paid under the Physician Fee Schedule effective CY 2020
+ Reducing Medicare coverage of bad debts from 65 percent to 25 percent over three years (with an exemption for rural hospitals with fewer than 50 beds, Critical Access Hospitals, Rural Health Clinics and Federally Qualified Health Centers)

The regulatory proposals, which would save an estimated $6 billion over 10 years, include:

+ Encouraging the adoption of high-value devices through bundled payment demonstrations
+ Improving transparency for health care coverage determinations
+ Phasing in the use of encounter data for Medicare Advantage payment systems by increasing the weight of encounter-data-based risk scores over subsequent years by moving to a risk score incorporating 75 percent of the encounter data/fee-for-service-based risk score in payment year 2021 and 100 percent in 2022
+ Improving payment accuracy by addressing overbilling and overutilization of certain items and services
+ Expanding Medicare Advantage risk adjustment data validation audits annually until the current level doubles in CY 2023

Medicaid

The president's budget includes Medicaid-related legislative proposals that would result in approximately $1.5 trillion in savings to Medicaid over 10 years. It is unlikely that these proposals will move forward with a Democratic House, however. For example, these proposals include the implementation of the 2017 repeal-and-replace bill known as Graham-Cassidy-Heller-Johnson, which allows states to implement a per-capita cap or to block grant financing structures for the Medicaid program and repeal Medicaid expansion. (This proposal was also included in last year's budget request.)

The president's budget calls for continued Medicaid Disproportionate Share Hospital allotment reductions from FY 2026 through FY 2029. These reductions were also included in last year's budget and would be in addition to current law reductions between FY 2020 and FY 2025. The proposal calls for implementing work requirements or community service for "able-bodied, working-age individuals" as a condition of eligibility for certain programs, such as Medicaid or Temporary Assistance for Needy Families. In addition, the budget calls for giving states the option to apply asset tests to those eligible for Medicaid under Modified Adjusted Gross Income eligibility standards.

There are also a few regulatory proposals relating to Medicaid, which have a higher likelihood of being implemented given that they do not require the divided Congress to act. These proposals include testing models to improve maternal mortality and morbidity, allowing states to conduct more frequent Medicaid eligibility determinations (compared to the current once every 12 months requirement), requiring more complete and timely provider-level data on supplemental payments, and changing the Non-Emergency Medical Transportation (NEMT) benefit from mandatory to optional. (Of note, a proposal to re-examine current regulations relating to NEMT coverage and providing states greater flexibility in covering the NEMT benefit is currently on the CMS unified agenda and is expected to be published by May 2019.)

Marketplace

The president's budget includes a few legislative proposals relating to the Marketplace. As noted, the budget calls for implementing Graham-Cassidy-Heller-Johnson, which would establish a Market-Based Health Care Grant Program that would use block grant funding for Marketplace premiums, cost sharing subsidies and Medicaid expansion. Similar to last year's budget, this year's budget includes legislative proposals for mandatory appropriation for Cost-Sharing Reduction payments through CY 2020, and for reducing the grace period for individuals on Marketplace plans to make premium payments from 90 days to 30 days. Again, these are legislative proposals which would require an act of Congress to be implemented.

Program Integrity

The budget includes Medicare and Medicaid program integrity proposals. Regulatory proposals include requiring states to assign unique identifiers to personal care service attendants that would be listed on claims along with dates of service provision, and expanding prior authorization for durable medical equipment, prosthetics, orthotics and supplies as a condition of Medicare payment.

Legislative proposals relating to program integrity include granting the Centers for Medicare and Medicaid Services (CMS) the authority to collect overpayments from states that spend federal resources on ineligible or misclassified beneficiaries, streamlining the Medicaid provider termination process, and requiring states to screen and automatically deny "unusual personal care services claims." The budget refers to unusual personal care services claims as duplicative services, services provided by personal care service attendants not meeting state qualification requirements, and services rendered to individuals no longer eligible for Medicaid. This provision was included in last year's budget.

Other program integrity legislative proposals include providing the Secretary with the authority to revoke or deny Medicare billing privileges based on medical board or Independent Review Organization determinations, and allowing CMS to implement civil monetary penalties to Medicare providers and suppliers for failure to report changes to information provided during enrollment or revalidation.

For more information, please contact Mara McDermott, Rodney Whitlock, Katie Weider or Emma Zimmerman.