

Policy Update

Analyzing the President's FY 2021 Budget: Key HHS Proposals



Summary

On February 10, 2020, the White House released [its \\$4.8 trillion FY 2021 budget proposal](#). The budget outlines the administration's priorities for the upcoming fiscal year. In the area of health care, the President requested \$94.5 billion in discretionary budget authority for the US Department of Health and Human Services (HHS), which represents a 10 percent decrease from the 2020 enacted level. Additionally, the budget proposes targeted savings of \$1.6 trillion in CMS mandatory programs, like Medicare and Medicaid over the next decade.

The administration's annual budget should be viewed as a messaging tool: most of the legislative policies are unlikely to be enacted. With a Democrat-controlled House of Representatives, controversial 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 existing statutory authority to move forward with regulatory action on the topic. Proposals categorized as regulatory should be monitored closely, however, as the Administration is more likely to have authority to advance changes through regulation, and is more likely to try to do so.

This week Secretary Azar will defend the [HHS budget](#) before Congress. On Thursday, February 13th, Secretary Azar will testify before the [Senate Committee on Finance](#) regarding the budget.

Below we have highlighted key proposals from the HHS Budget. (Of note, the Center for Medicare and Medicaid Services (CMS) budget justification is not currently available. As additional information is available, we will update this document.)

Prescription Drugs

In May 2018, the Administration published the American Patients First Blueprint, which established four focus areas for addressing the rising cost of prescription drugs through increased competition, better negotiation, incentives for lower list prices, and lowering out-of-pocket costs.

Unlike the Blueprint, the budget includes no specific regulatory proposals on prescription drug pricing. Instead, it allows for savings of \$135 billion over 10 years from bipartisan drug pricing legislative proposals. It broadly mentions support for legislative efforts to improve the Medicare Part D benefit by establishing an out-of-pocket maximum, improving incentives to contain costs, and reducing out-of-pocket expenses for seniors. The proposed budget also includes support for legislation that addresses policies that have stunted generic drug development, promote more competition, and increase patient access to more affordable medications.

Arguably, the legislation referenced in the budget could be the bipartisan proposal from Senate Finance Committee Chairman Chuck Grassley (R-IA) and Ranking Committee Democrat Ron Wyden (D-OR): the Prescription Drug Pricing Reduction Act of 2019. This bill includes a number of policies that align with proposals in the President's budget. By not including specific regulatory reforms around lowering the cost of prescription drugs, the Administration is signaling a preference that Congress reconcile differences between the Grassley/Wyden proposal and House Speaker Nancy Pelosi's (D-CA) bill, the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3). H.R. 3 is the prescription drug pricing reform package that was developed and supported by House Democrats, which includes many policy changes found in the Grassley-Wyden bill, but also includes provisions relating to Medicare price negotiation. A summary of the differences and similarities between H.R. 3, the Grassley/Wyden proposal, and the Administration's previous regulatory actions as it relates to prescription drug pricing can be found [here](#).

The budget also includes proposals to revise the 340B Program. These proposals include allowing the Health Resources and Services Administration (HRSA) to collect a user fee of 0.1 percent for total 340B drug purchases from participating covered entities, which is estimated to save [\\$24 million over ten years](#). It also requests explicit general regulatory authority over the 340B program, which would allow HRSA to require covered entities to report both their savings and how these savings are used.

Medicare

The budget includes legislative and regulatory proposals related to Medicare, estimated to yield an estimate gross savings of \$756 billion over 10 years in Medicare. (The net impact of the Medicare specific proposals is \$450 billion over 10 years.) The budget mostly focuses on legislative proposals, which are less likely to be enacted. Noteworthy legislative proposals include the following.

- + Lowering the Medicare payment update for skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals from FY 2021 through FY 2025. Beginning in FY 2026, CMS would establish a unified post-acute care payment system that would span skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals, with payments based on episodes of care and patient characteristics rather than the site of service. Payment rates would be budget neutral in FY 2026, risk adjusted, and set prospectively on an annual basis, with episode grouping and pricing based on the average cost for providing post-acute care services for a diagnosis, similar to the Diagnosis-Related Group methodology under the Inpatient Prospective Payment System (IPPS). This proposal is estimated to save Medicare \$101.5 billion over 10 years.
- + Making site-neutral payments between on-campus hospital outpatient departments and physician offices for certain services, including imaging tests, clinic visits, and drug administration. This proposal, if implemented, would represent a substantial expansion of site neutral policies recently advanced by Congress and the Administration in recent years. The Administration proposes to exempt rural hospitals, which would be a bigger carve-out than the Administration has previously been willing to support. This proposal was included in last year's budget proposal and is expected to save Medicare \$117.2 billion over 10 years.
- + Requiring all off-campus hospital outpatient departments to be paid under the Physician Fee Schedule, effective CY 2021. Site-neutral payments would apply to emergency departments, cancer hospitals, and off-campus hospital outpatient departments who were granted protections from adjusted payments under the Bipartisan Budget Act of 2015. This proposal was included in last year's budget proposal.
- + Reforming uncompensated care payments by creating a payment funding pool, equal to FY 2019 funding levels and grown annually by the Urban Consumer Price Index. Uncompensated care payments would be paid out of the Treasury, rather than the Medicare Trust Fund, and distributed according to a hospital's share of charity care and non-Medicare bad debt. This proposal, which is effective in FY 2022, would generate net savings of \$87.9 billion over 10 years.
- + Reducing Medicare reimbursement of bad debt payment. The [Major Savings and Reforms document](#) notes that the budget reduces bad debt payment from 65 percent to 25 percent of bad debt—copayments or deductibles that beneficiaries fail to pay—over three years. This proposal is estimated to save \$33.6 billion over 10 years and was also included in last year's budget request (as well as many budget proposals before that).

- + The budget proposal also proposes significant legislative reform of Graduate Medical Education (GME) funding. The legislative proposal would consolidate federal GME spending from Medicare, Medicaid, and the Children's Hospital GME Program into a single grant program for teaching hospitals. This proposal was included in last year's budget and is projected to save \$52.2 billion over 10 years.
- + Extending the criterion to qualify for a higher long-term care hospital (LTCH) reimbursement rate. Medicare pays a higher prospective payment rate to LTCHs when admissions follow an acute care hospital stay with three or more days in an intensive care unit, or the hospital provides at least 96- hours of mechanical ventilation services. Absent one of these circumstances, these hospitals receive a lower Medicare payment rate, comparable to acute care hospitals under the IPPS. Effective FY 2021, this proposal would increase this threshold to at least an eight-day stay in an ICU. This proposal is estimated to save \$9.4 billion over 10 years.
- + Expanding the basis for beneficiary assignment to an Accountable Care Organization (ACO) to include a broader set of primary care providers, including nurse practitioners, physician assistants, and clinical nurse specialists.
- + Removing the Medicare Advantage benchmark caps and the double bonus payments initiated by the Affordable Care Act (ACA). The ACA changed the methodology for calculating the Medicare Advantage benchmark and capped it at the pre-ACA benchmark. This proposal eliminates the benchmark cap. The budget also removes the quality double-bonus for plans in eligible counties. This is estimated to save \$1.2 billion over 10 years.

The budget outlines only four regulatory proposals as it relates to Medicare. The most noteworthy regulatory proposal is implementing a Medicare Advantage risk adjustment model. The budget proposes to accelerate the phase-in of a new risk adjustment model and is expected to save \$40.6 billion over 10 years.

Medicaid

The President's budget includes Medicaid-related legislative proposals that would result in approximately \$920 billion in reductions to the Medicaid program over 10 years. It is highly unlikely that these proposals will move forward with a Democratic House, however. For example, the budget includes the legislative proposal "President's Health Reform Vision Allowance." Information on the specifics of this budget proposal are limited other than to say that it would build on the Executive Order, "[Improving Price and Quality Transparency in American Healthcare To Put Patients First.](#)" As the President's Health Reform Vision Allowance relates to Medicaid, the budget states "Medicaid reform will restore balance, flexibility, integrity, and accountability to the state-federal partnership. Medicaid spending will grow at a more sustainable rate by ending the

financial bias that currently favors able bodied working-age adults over the truly vulnerable.” This proposal is estimated to reduce \$744 billion in Medicaid funding over 10 years.

Another Medicaid proposal includes requiring “able-bodied, working-age individuals” to find employment, train for work, or volunteer in order to receive Medicaid benefits. The Trump Administration and some states have already tried to encourage states to implement work requirements by applying for Section 1115 waivers; however, many of these policies have been stopped through legal challenges. This proposal is projected to reduce \$152.4 billion in Medicaid funding over 10 years.

Additionally, the budget proposes allowing states to apply asset tests to Modified Adjusted Gross Income (MAGI) Medicaid populations. Currently, MAGI Medicaid groups, including children and low-income adults, do not have to undergo an asset test for Medicaid eligibility purposes. Only those in the aged, blind, and disabled Medicaid group have asset tests. If this change were to be implemented the new adult group and other MAGI Medicaid groups could be required to do an asset test. This proposal is estimated to reduce \$2.2 billion in Medicaid funding over 10 years, and was also included in last year's budget.

The president's budget calls for removing states authority to increase allowable home equity levels for Medicaid eligibility. It includes continued Medicaid Disproportionate Share Hospital (DSH) allotment reductions through FY 2030. The DSH allotment reductions were also included in last year's budget. It also calls for modifying the Medicaid Institution for Mental Disease (IMD) exclusion to provide states flexibility in offering inpatient mental health services to Medicaid beneficiaries with serious mental illness. (Of note, the Trump Administration released a [State Medicaid Director letter in 2018](#) outlining opportunities for states to submit 1115 waivers to waive the Medicaid IMD exclusion for individuals with SMI and serious emotional disturbances.)

The budget also outlines legislative changes as it relates to Medicaid coverage for inmates. It proposes to prohibit states from terminating CHIP coverage for inmates, and also to prohibit states from terminating Medicaid coverage for the six months that the inmate is in custody. Both proposals are new to this year's budget request.

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. For example, the budget highlights providing states the option to conduct more frequent Medicaid eligibility redeterminations and notes that the CMS will soon release the Proposed Rule “Strengthening the Program Integrity of the Medicaid Eligibility Determination Process” regarding the issue. Additionally, the budget refers to increased provider-level data on supplemental payments. CMS recently published the [Proposed Rule Medicaid Fiscal Accountability Regulation \(MFAR\)](#), which increases provider level reporting and makes structural changes to Medicaid supplemental payments. This suggests that the Administration is still very interested in finalizing the

MFAR regulation. Finally, the budget proposes to change the Non-Emergency Medical Transportation (NEMT) benefit from a mandatory benefit to an optional benefit. (Of note, making NEMT coverage optional was included in last year's President's budget. However, the regulation providing states greater flexibility in covering the NEMT benefit is no longer included on [CMS' unified agenda](#).)

Marketplace

The budget does not include any proposals that would make substantive changes to the Exchange Marketplace. It allocates \$1.5 billion for Marketplace-related program management (down approximately \$226 million from 2020), to be funded primarily through user fees collected from insurers operating on the federal exchange and state-based exchanges on the federal platform. The budget extends the use of these user fees to cover nearly all federal administrative costs associated with operating the Marketplace (\$25 million would come from the Healthcare Fraud and Abuse Control appropriation). CMS reduced user fees to 3% of premiums on the federal exchange and 2.5% of premiums on state-based exchanges on the federal platform as part of the [Notice of Benefit and Payment Parameters Rule](#) ("payment notice") for plan year 2020, and proposed maintaining that level in the [payment notice for 2021](#). However, the proposed 2021 payment notice also included a request for comments on an alternative proposal to reduce the user fee rates further.

Program Integrity

The FY 2021 budget proposal introduces program integrity measures to ensure the Medicare and Medicaid programs are "paying the right amount to the right entity for the right beneficiary." The Healthcare Fraud and Abuse Control (HCFAC) Program and the Medicaid Integrity Program constitute the largest federal investments in healthcare program integrity. The FY 2021 proposed budget provides \$2.3 billion in mandatory and discretionary spending for program integrity investments.

The Administration's goal for these proposals is to prevent inappropriate payments, reduce spending, protect beneficiaries and reduce time wasted on fraud and abuse investigations. In the FY 2021 budget proposal, there are numerous legislative and administrative proposals estimated to save \$31 billion and \$220 million, respectively, over the next 10 years.

Legislative proposals included in the FY 2021 proposed budget include the following.

- + **Expanding prior authorization in Medicare FFS**
CMS will explore options within their current authority through the Center for Medicare and Medicaid Innovation (CMMI) to test if applying prior authorization on low-value services can reduce Medicare costs by reducing unnecessary utilization.

Prior authorization has been a tool the current Administration has previously used to reduce payments for services. In the CY 2020 Hospital Outpatient Prospective Payment System Final Rule ([CMS-1717-FC](#)) CMS established a nationwide process for prior authorization for [certain hospital outpatient department services which will begin July 1, 2020](#). Like in the budget proposal, the identified services are those that CMS identified as being at high risk for fraud and abuse.

- + **Increasing provider reporting requirements**
 The Administration proposes the annual re-verification of national provider identifiers, the expansion of reporting open payments, and penalties for providers failing to meet reporting requirements.
- + **Improving payment accuracy within MA**
 The budget proposal would require MA plans to submit medical records for review in CY 2022 to confirm diagnoses for risk-adjusted payments.

Additional Provisions

Rural Health

The FY2021 proposed budget includes a number of specific legislative proposals to address the increasing challenges facing providers in rural communities:

- + **Inpatient Hospital Wage Index:** This proposal creates a statutory demonstration to test comprehensive wage index reform. The demonstration redefines the labor market area to commuting data by zip code, identifies an alternative source for wage data, repeals the rural floor and other reclassifications and special payment adjustment (e.g., out-migration adjustment), and provides civil monetary penalty authority to penalize hospitals that submit inaccurate or incomplete data. The demonstration would aim to improve hospital wage index accuracy, reduce sharp differences in the wage index and Medicare payments between nearby hospitals, address the divergence between low wage and high wage hospitals, and protect access to healthcare in rural areas.
- + **Rural Emergency Hospitals:** This proposal allows Critical Access Hospitals to voluntarily convert to an emergency hospital that does not maintain inpatient beds. This new facility type would receive the same Medicare payment rates as other emergency departments paid under the outpatient prospective payment system, plus an additional payment to assist with capital costs. The capital cost adjustment equals 10 percent of the 5-year average of the facility's payment.
- + **Update Medicare Telehealth Benefit Through Value-Based Payment Models:** This proposal expands Medicare Fee-for-Service's telehealth benefit by removing existing barriers to telehealth services for providers participating in Medicare fee-

for-service advanced Alternative Payments Models, which require more than nominal financial risk.

- + Update Payment for Rural Health Clinics: This proposal establishes a new Medicare prospective payment system for rural health clinics with annual updates based on a market basket derived from cost report data and rebased periodically, similar to the recently-implemented payment system for Federally Qualified Health Centers. This new payment system addresses concerns that current payment to rural health clinics is inadequate due to caps based on the Medicare Price Index. It is estimated to save \$1.8 billion over 10 years.
- + Increase Medicare Telehealth Services for Federally Qualified Health Centers and Rural Health Clinics: This proposal allows Rural Health Clinics and Federally Qualified Health Centers to be distant site providers for Medicare telehealth and reimburses for these services at a composite rate similar to payment for comparable telehealth services under the Medicare Physician Fee Schedule.

These policy changes were not included in last year's budget proposal. While this reflects the Administration's continued interest in supporting policies that may help address access to care in rural communities, these reforms are legislative (not regulatory), and so likely would require congressional action to implement.