Overview of Select Health Provisions – FY 2015 Administration Budget Proposal

On March 4, 2014, President Obama released his Administration's FY 2015 budget proposal to Congress. The budget contains a number of provisions of interest to health care providers and patients. This budget serves as the starting point for Congress as it works on budget issues for FY 2015. This budget also assumes enactment of some legislative proposals that would make key changes in health care policy. These changes are included for the purposes of guiding overall policy and obtaining savings.

Health Resources and Services Administration (HRSA)

HRSA is the principal federal agency charged with improving access to health care services for people who are medically underserved. To support this mission, the FY 2015 Budget requests $10.8 billion, including $1.4 billion for new mandatory proposals.

Health Centers

Health centers are a critical component of the health care system, providing comprehensive primary care services in medically underserved communities. The Budget includes $4.6 billion for the Health Center program, including $3.6 billion in mandatory funding provided through the Affordable Care Act, a total increase of $960 million above FY 2014. Funding will serve approximately 31 million patients at over 1,300 health centers that operate more than 9,500 service delivery sites and provide care in every state, the District of Columbia, Puerto Rico, the United States Virgin Islands, and the Pacific Basin.

340B Prescription Drug Discount Program

The 340B program provides discounts on outpatient prescription drugs to programs that serve a high number of low-income patients. Participants in the 340B program include safety-net clinics and hospitals such as community health centers, Indian Health Service tribal clinics, children's hospitals, critical access hospitals, Federally Qualified Health Centers and certain other community-based providers. The Budget includes $17 million for the 340B program, an increase of $7 million above FY 2014.

Rural Health Outreach Grants

The Budget includes $57 million for Rural Health Outreach Grants to improve access to quality care, coordination of care, and integration of services to the 50 million Americans living in rural areas. Funding will also focus on improving the health care professional workforce in rural areas.

Workforce

National Health Service Corps

The $4 billion in new mandatory resources from FY 2015 through FY 2020 is in addition to $100 million in discretionary funding and $310 million in current law funding for FY 2015 for the National Health Service Corps. Corps clinicians serve in medical facilities in high-need areas of the country, including rural areas and federally-funded health centers, where access to care is limited and where shortages of health care professionals often persist. The new funding would be directed to support a workforce of 15,000 providers in FYs 2015–2020, estimated to serve the primary care needs of more than 16 million patients.

Training and Assistance for Health Professionals

In this budget proposal, $144 million is provided to develop the nation's nursing workforce through the enhancement of advanced nursing education and practice and increased nursing education opportunities for individuals from disadvantaged backgrounds; $32 million for Oral Health Training programs; $37 million for Primary Care Training and Enhancement program, $33 million for Geriatric programs, $18 million for Public Health Workforce Development, and $8 million for Mental and Behavioral Health Education and Training programs.

The Budget also provides for two new workforce initiatives, including $10 million to support a new Clinical Training in Interprofessional Practice program to increase the capacity of community-based primary health care teams to deliver care. The budget also would provide $4 million to fund new Rural Physician Training grants to help rural-focused training programs recruit and graduate students most likely to practice medicine in underserved rural communities.

Graduate Medical Education

Targeted Support for GME

The Budget includes $530 million in mandatory funding for a new program, Targeted Support for Graduate Medical Education. This new competitive grant program would fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities to expand residency training, with a focus on ambulatory and preventive care, in order to advance the Affordable Care Act's goals of higher value health care that reduces long-term costs.

The new Targeted Support for Graduate Medical Education Program would incorporate two existing programs, the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program. Current awardees in those programs would be eligible to compete for funding through the Targeted Support's competitive grant program, with a minimum of $100 million set-aside specifically for children's hospitals in FY 2015. The Budget proposes to continue mandatory funding for the new Targeted Support for Graduate Medical Education program annually in FYs 2015-2024, for a total investment of $5.2 billion.

Better Align Graduate Medical Education Payments with Patient Care Costs
The Medicare Payment Advisory Commission (MEDPAC) has found that existing Medicare add-on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs that hospitals incur. The budget would reduce these payments by 10 percent, beginning in 2015. In addition, the Secretary of Health and Human Services would be granted the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage training of primary care residents and emphasize skills that promote high-quality and high-value health care. [$14.6 billion in savings over 10 years]

National Institutes of Health

The FY 2015 Budget includes $30.4 billion for the National Institutes of Health (NIH), an increase of $211 million, or 0.7 percent over FY 2014. For the National Heart, Lung and Blood Institute, the budget proposes a funding level of $2.988 billion. In FY 2015, NIH estimates it will support a total of 34,197 research project grants, including 9,326 new and competing awards. The budget estimates about 83 percent of the funds appropriated to NIH would go to the extramural community. Approximately 11 percent of the budget would support intramural research and training activities.

Accelerating Medicines Partnership
In FY 2015, NIH will also continue to implement the Accelerating Medicines Partnership (AMP), a venture between NIH, ten biopharmaceutical companies, and several non-profit organizations to jointly identify and validate promising biological targets of disease. AMP's initial focus is on three- to five-year pilot projects in three disease areas: Alzheimer's disease, type-2diabetes, and autoimmune disorders (focus on rheumatoid arthritis and lupus).

NIH Diversity Efforts
NIH will also continue to implement a series of steps to enhance its effort to recruit and advance the careers of people traditionally underrepresented in the biomedical

and behavioral research workforce. Such steps include providing relatively under-resourced institutions with opportunities to provide mentorship and resources to undergraduate students interested in pursuing a biomedical research career. Other efforts include building a nationwide consortium that will connect students, postdoctoral fellows, and faculty to experienced mentors, and improving upon data collection and evaluation efforts to determine the most effective approaches. A total of $767 million is estimated in FY 2015 to support training 15,715 of the next generation of research scientists through the Ruth L. Kirschstein National Research Service Awards program. The Budget proposes a two percent stipend increase for predoctoral and postdoctoral trainees in FY 2015.

Research Project Grants

NIH estimates that it will devote $16.2 billion, or 53 percent of its total budget, to finance a total of 34,197 competitive, peer-reviewed, and largely investigator-initiated research project grants (RPGs) in FY 2015. Within this total, NIH anticipates supporting 9,326 new and competing RPGs, an increase of 329 grants over FY 2014 levels.

Supplemental Grant Funding

An additional $970 million would be provided to increase the number of new grants funded by 650, and provide additional resources for activities including the BRAIN Initiative, improving the sharing and analysis of complex biomedical data sets, expanding research on Alzheimer's disease and vaccine development, and further accelerating partnership efforts to identify and develop new therapeutic drug targets.

Centers for Disease Control and Prevention (CDC)

The Budget includes $1.1 billion for chronic disease prevention and health promotion activities, $110 million below FY 2014.

CDC will continue the Partnerships to Improve Community Health program created in FY 2014, at the same funding level of $80 million. This program aims to reduce the burden of chronic diseases.

In FY 2015, CDC will continue to fund the State Public Health Approaches to Chronic Disease Prevention program, which supports states in implementing strategies to promote health and prevent and control chronic diseases and their risk factors. The coordinated approach is comprised of the Diabetes, Heart Disease and Stroke Prevention, School Health, and Nutrition, Physical Activity, and Obesity state programs. Collectively, these programs support a set of complementary activities and

intervention strategies in four domains: epidemiology and surveillance, supportive environments, improvements in health systems, and community-clinical linkages.

The budget eliminates the REACH program and the Preventive Health and Health Services Block Grant, noting that other CDC activities address the goals of these programs through the State Public Health Approaches to Chronic Disease Prevention program and the Community Chronic Disease Prevention Grant program.

The Budget also proposes targeted reductions to select direct health care programs such as cancer screenings, with the rationale that the Affordable Care Act's consumer protections and Medicaid expansion will promote coverage and use of new preventive services, such as screenings for populations formerly served through CDC grant programs.

Agency for Healthcare Research and Quality

The FY 2015 Budget includes a total program level of $440 million for the Agency for Healthcare Research and Quality (AHRQ), $24 million less than the FY 2014 level.

Patient Centered Health Research

The Budget includes $106 million for Patient Centered Health Research (also known as Patient Centered Outcomes Research or Comparative Effectiveness Research), provided through the Patient Centered Outcomes Research Trust Fund. The fund, established by the Affordable Care Act, transfers funding to AHRQ to build research capacity, translate and disseminate comparative clinical effectiveness research, and establish grants to train researchers.

The Budget includes $11 million, $12 million less than FY 2014, for the AHRQ Prevention and Care Management research portfolio which supports improved evidence-based clinical decision-making for preventive services through the U.S. Preventive Services Task Force (USPSTF). The USPSTF is an independent non-governmental panel focused on evaluating risks and benefits of clinical preventive services, making recommendations about which services should be incorporated into primary medical care, and identifying research priorities. AHRQ provides scientific and administrative support to the Task Force, including topic selection, methods development, systematic evidence review, and dissemination.

FY 2015 Budget Assumes Enactment of Some Pending Legislative Proposals

The FY 2015 Budget includes a package of Medicare legislative proposals that would save $407.2 billion over 10 years. Select provisions include:

Reduce Medicare Coverage of Bad Debts
Generally, Medicare currently reimburses 65 percent of bad debts resulting from beneficiaries' non-payment of deductibles and coinsurance after providers have made reasonable efforts to collect the unpaid amounts. Starting in 2015, the budget proposal would reduce bad debt payments to 25 percent over 3 years for all providers who receive bad debt payments. This proposal would more closely align Medicare policy with private payers, who do not typically reimburse for bad debt. [$30.8 billion in savings over 10 years]

Reduce Critical Access Hospital (CAH) Reimbursements to 100 percent of Costs
Medicare currently pays CAHs 101 percent of reasonable costs. This proposal would reduce this rate to 100 percent beginning in 2015. [$1.7 billion in savings over 10 years]

Prohibit Critical Access Hospital Designation for Facilities that are Less Than 10 Miles from the Nearest Hospital
Beginning in 2015, this proposal would prevent hospitals that are within 10 miles of another hospital from maintaining designation as a CAH and receiving the enhanced payment rate. These hospitals would instead be paid under the applicable prospective payment system. [$720 million in savings over 10 years]

Modernize Payments for Clinical Laboratory Services
This proposal would lower the payment rates under the Clinical Laboratory Fee Schedule by -1.75 percent every year from 2016 through 2023 to better align Medicare payments with private sector rates. The Secretary of Health and Human Services would also have the authority to adjust payment rates under the schedule in a budget neutral manner. Additionally, the Budget supports policies to encourage electronic reporting of laboratory results. [$7.9 billion in savings over 10 years]

Modify Reimbursement for Part B Drugs
To reduce excessive payment for Part B drugs administered in the physician office and hospital outpatient settings, the budget would lower payment from 106 percent of the Average Sales Price (ASP) to 103 percent of ASP starting in 2015. If a physician's cost for purchasing the drug exceeds ASP + 3 percent, the drug manufacturer would be required to provide a rebate such that the net cost to the provider to acquire the drug equals ASP + 3 percent minus a standard overhead fee to be determined by the Secretary. This rebate would not be used in calculating ASP. The Secretary would also be given authority to pay a portion or the entire amount above ASP in the form of a flat fee rather than a percentage, with the modification to be made in a budget neutral manner relative to ASP + 3 percent. [$6.8 billion in savings over 10 years]

Exclude Certain Services from the In-Office Ancillary Services Exception
The in-office ancillary services exception to the physician self-referral law was intended to allow physicians to self-refer for certain services to be furnished by their group practices for patient convenience. The budget notes that while there are many appropriate uses for this exception, certain services, such as advanced imaging and outpatient therapy, are rarely furnished on the same day as the related physician office visit. Additionally, the budget suggests there is evidence that this exception may have resulted in overutilization and rapid growth of certain services. Effective calendar year 2016, this proposal would amend the in-office ancillary services exception to prohibit certain referrals for radiation therapy, therapy services, advanced imaging, and anatomic pathology services except in cases where a practice meets certain accountability standards, as defined by the Secretary. [$6 billion in savings over 10 years]

Require Prior Authorization for Advanced Imaging
Currently, CMS has authority to require prior authorization for Medicare Durable Medical Equipment service items. The budget proposes that this authority be extended to all Medicare fee-for-service items, particularly those service items that are at the highest risk for improper payment. Specifically, the budget proposal would require the Secretary to implement prior authorization in two service areas: power mobility devices and advanced imaging. [$90 million in savings over 10 years]

Allow Civil Monetary Penalties for Providers and Suppliers who Fail to Update Enrollment Records
Currently, providers and suppliers are required to update enrollment records to remain in compliance with the Medicare program. This budget proposal would allow penalties if providers and suppliers fail to update their records. [$90 million in savings over 10 years]

Medicare Beneficiary Provisions

Increase Income-Related Premiums under Medicare Part B and Part D
Under Medicare Parts B and D, certain beneficiaries pay higher premiums based on their higher levels of income. Beginning in 2018, this proposal would restructure income-related premiums under Medicare Parts B and D by increasing the lowest income-related premiums five percentage points, from 35 percent to 40 percent, and creating new tiers every 12.5 percentage points until capping the highest tier at 90 percent. The proposal maintains the income thresholds associated with these premiums until 25 percent of beneficiaries under Parts B and D are subject to these premiums. [$52.8 billion in savings over ten years]

Encourage the Use of Generic Drugs by Low Income Beneficiaries

Beginning in plan year 2016, this proposal would induce greater generic utilization by lowering copayments for generic drugs. Brand copayments would be increased to twice the level required under current law. The Secretary would have new authority to exclude brand drugs in therapeutic classes from this policy if therapeutic substitution is determined not to be clinically appropriate or a generic is not available. Brand drugs could be obtained at current law cost-sharing levels if beneficiaries successfully appeal. In addition, the change in cost-sharing would be applied to beneficiaries receiving a partial subsidy upon reaching the catastrophic coverage level. Beneficiaries qualifying for institutionalized care would be excluded from these increases. [$8.5 billion in savings over 10 years]

Modify Part B Deductible for New Enrollees

Beneficiaries who are enrolled in Medicare Part B are required to pay an annual deductible ($147 in calendar year 2014). This deductible helps to share responsibility for payment of Medicare services between Medicare and beneficiaries. To strengthen program financing and encourage beneficiaries to seek high-value health care services, this proposal would apply a $25 increase to the Part B deductible in 2018, 2020, and 2022 respectively for new beneficiaries beginning in 2018. Current beneficiaries or near retirees would not be subject to the revised deductible. [$3.4 billion in savings over 10 years]

Medicaid Provisions

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid

The budget proposal would track high prescribers and utilizers of prescription drugs in Medicaid. States are currently authorized to implement prescription drug monitoring activities, but not all states have adopted such activities. Under this proposal, states will be required to monitor high risk billing activity to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in the Medicaid program. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes to improve Medicaid integrity and beneficiary quality of care. [$540 million in savings over 10 years]

Extend the Medicaid Primary Care Payment Increase through CY 2015 and Include Mid-Level Providers (Workforce Initiative)

Effective for dates of service provided on January 1, 2013 through December 31, 2014, states are required to reimburse qualified providers at the rate that would be

paid for the primary care service under Medicare. The federal government covers 100 percent of the difference between the Medicaid and Medicare payment rate. This proposal would extend the enhanced rate through December 31, 2015, expand eligibility to mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care. [$5.4 billion in costs over 10 years]