Summary of Key Provisions in President’s Proposed FY2017 Budget

President Obama released his $4.23 trillion budget proposal for fiscal year (FY) 2017. Compared with estimates for the current year, the budget would increase outlays by $196 billion and increase revenue by $308 billion in FY2017. The White House said the plan would reduce the deficit by $2.9 trillion over 10 years. It would replace the sequester with tax and spending changes. The proposal includes $376 billion in health care savings, $955 billion from closing tax breaks for the wealthy, and $170 billion connected with an overhaul of immigration laws.

It is important to note the President’s budget is a proposal or request to Congress and is the start of the federal budgeting process. The President’s budget submission is referred to the House and Senate Budget Committees and to the Congressional Budgeting Office (CBO) where proposals may or may not be advanced by the Congress.

The following summary provides an overview of key U.S. Department of Health and Human Services (DHHS) proposals of interest to AHCA/NCAL membership. AHCA/NCAL will be heavily engaged as these proposals are considered by the Congress or possibly advanced by Executive Order.

**DHHS Budget Proposal**

For the Department of Health and Human Services, the White House is proposing $1.15 billion, a 10 percent increase over the FY2016 budget proposal. In the DHHS budget document, the Administration highlights efforts to continue building upon the Affordable Care Act (ACA) and delivery system reform. The latter refer to “proposals that will reward value and care coordination, rather than volume and care duplication. The budget also would increase the total number of DHHS employees from 77,583 to 79,406 with many of the new positions aimed at program integrity efforts.

Such initiatives align with Secretary Burwell’s departmental goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. Similar efforts are likely to be seen in Medicaid state-federal initiatives.

Of particular note are: a) a Medicare post-acute care bundling proposal similar to last year’s proposal; b) Medicare Advantage “reform goals;” c) further proposed reductions in bad debt also as proposed last year; d) freezing Medicare market basket increases; and e) expansion of a variety of Medicaid-financed home and community-based program authorities.
Agency for Healthcare Research and Quality (AHRQ)

Reducing Hospital Readmissions Database — In October 2015, AHRQ introduced a new Nationwide Readmissions Database, “the first all payer nationwide data resource that supports tracking and analysis of hospital readmission rates.” In the FY2017 budget blueprint, the Administration is proposing $8 million to continue this project.

Centers for Medicare and Medicaid Services (CMS)

In FY2017, the Administration’s CMS budget estimate is $1.0 trillion in mandatory and discretionary outlays, a net increase of $26 billion above the FY2016 level. Below are key CMS initiatives:

Medicare Program (Legislative Unless Noted Otherwise)

Medicare FFS and Alternative Payment Methods

- **Implement Bundled Payment for Post-Acute Care.** Beginning in 2021, this proposal would implement bundled payment for post-acute care providers, including long term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health providers. Payments would be bundled for at least 50 percent of the total payments for post-acute care providers. Rates would be based on patient characteristics and other factors will be set so as to produce a permanent and total cumulative negative adjustment of 2.85 percent by 2023. Other Medicare fee-for-service rules, such as beneficiary cost-sharing obligations, would remain in place. Because no additional details about program design and implementation are included in this proposal, it is difficult to estimate precisely what the impact to skilled nursing providers would be. However, any proposal implementing bundled payments for such a large portion of Medicare revenues would very likely have a significant impact on skilled nursing centers. Estimated savings of $9.9 billion over 10 years.

- **Expand Basis for Beneficiary Assignment for Accountable Care Organizations to include Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists.** This proposal would allow the Secretary to base beneficiary alignment in the Medicare Shared Savings Program on a broader set of primary care providers. Under the proposal, beneficiaries would be assigned to Accountable Care Organizations on the basis of primary care services delivered by nurse practitioners, physician assistants, and clinical nurse specialists. Statute requires that assignment of beneficiaries to an Accountable Care Organization be based on their utilization of primary care services provided by physicians. Expanding the assignment of beneficiaries to nurse practitioners, physician assistants, and clinical nurse specialists, in addition to physicians, could broaden the scope of Accountable Care Organizations to better reflect the types of professionals that deliver primary care services to fee-for-service beneficiaries. Some Medicare beneficiaries, especially those in rural or underserved areas, receive most or all of their primary care from non-physician practitioners. This proposal would result in a greater number of Medicare fee-for-service beneficiaries who rely on these practitioners for their care being assigned to Accountable Care Organizations.
Because the proposal would result in more Medicare beneficiaries being aligned with an ACO, skilled nursing providers may see an increase in the number of ACO patients they serve depending on their individual markets. Overall impact to skilled nursing providers would be low. Estimated savings of $150 million over 10 years.

- **Allow CMS to Assign Beneficiaries to Federally Qualified Health Centers and Rural Health Clinics Participating in the Medicare Shared Savings Program.** This proposal would allow the Secretary to assign more Medicare fee-for-service beneficiaries to Accountable Care Organizations under the Medicare Shared Savings Program based on primary care services furnished to them by Federally Qualified Health Centers and Rural Health Clinics. Federally Qualified Health Centers and Rural Health Clinics are important providers of primary care services and part of the safety net for the nation’s health care system. This proposal could result in assignment of a greater number of Medicare fee-for-service beneficiaries to Accountable Care Organizations and would stimulate greater interest in the program by Federally Qualified Health Centers and Rural Health Clinics and support the program’s goals to improve quality of care for Medicare fee-for-service beneficiaries while reducing overall growth in costs. Because the proposal would result in more Medicare beneficiaries being aligned to an ACO, skilled nursing providers could see an increase in the number of ACO patients they serve, particularly if they operate in markets with FQHCs and RHCs. Overall impact to skilled nursing providers would be low. Estimated savings of $80 million over 10 years.

- **Establish a Bonus Payment for Hospitals Cooperating with Certain Alternative Payment Models.** Under this proposal, hospitals that furnish a sufficient proportion of their services through eligible alternative payment entities would receive a bonus payment starting in 2022. Bonuses would be paid through the Inpatient Prospective Payment System permanently and through the Outpatient Prospective Payment System until 2024. Each year, hospitals that qualify for this bonus would receive an upward adjustment to their base payments. Reimbursement through the inpatient and outpatient prospective payment systems to all providers would be reduced by a percentage sufficient to ensure budget neutrality. The proposal could accelerate the rate at which hospitals opt to participate in alternative payment models, but the impact to skilled nursing providers would be low.

- **Adjust Payment Updates for Certain Post-Acute Care Providers.** This proposal would reduce market basket updates for inpatient rehabilitation facilities, long term care hospitals, and home health agencies by 1.1 percentage points in FY2017 and each year FY2019 through FY2026. For FY2018, the statute requires an update of 1 percent for these post-acute care providers (established by the Medicare and CHIP Reauthorization Act (MACRA) of 2015). Payment updates for these providers would not drop below zero as a result of this proposal. This proposal will reduce market basket updates for skilled nursing facilities under an accelerated schedule, beginning with a -2.5 percent update in FY2017; -2 percent in FY2019; -1 percent in each year FY2020-2023; and tapering down to a -0.97 percent update in FY2024. Payment updates may drop below zero as a result of this proposal for skilled nursing facilities. The impact of this proposal on skilled nursing providers would be high, as it represents a significant decrease to SNFs’ Medicare rates. Estimated savings of $86.6 billion over 10 years.
• **Encourage Appropriate Use of Inpatient Rehabilitation Facilities.** This proposal would adjust the standard for classifying a facility as an Inpatient Rehabilitation Facility. Under current law, at least 60 percent of patient cases admitted to an Inpatient Rehabilitation Facility must meet 1 or more of 13 designated severity conditions. This standard was changed to 60 percent from 75 percent in the Medicare, Medicaid, and SCHIP Extension Act of 2007. Beginning in 2017, this proposal would reinstate the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. The impact of this proposal on skilled nursing centers would be medium, depending on the availability of IRFs in certain markets, as the proposal could result in the shifting of some patients from IRFs to skilled nursing centers. Estimated savings of $2.2 billion over 10 years.

• **Medicare Bad Debt.** Building upon past year reductions to 65 percent, starting in FY2017, the proposal would further reduce bad debt payments to 25 percent over three years for all providers who receive bad debt payments. Estimated savings of $32.9 billion over ten years.

• **Implement Value-Based Purchasing for Additional Providers.** This proposal would implement a budget neutral value-based purchasing (VBP) program for several provider types beginning in 2018, including skilled nursing facilities (SNFs), requiring that at least two percent of payments must be tied to the quality and efficiency of care in the first two years of implementation and at least five percent beginning in 2020. At this time, it is unclear how this proposal would interact with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA), which mandated a VBP program for skilled nursing facilities. Specifically, PAMA established a two percent withhold to SNF Part A payments that can be partially earned back based on a SNF’s rehospitalization rate and level of improvement in 2019. If passed, this proposal would have a significant impact on SNF reimbursement and operations.

• **Reform Medicare Hospice Payments.** The proposal would reduce market basket updates for hospice providers by 1.7 percent in 2018, 2019, and 2020. The proposal also permits the Secretary to implement a hospice-specific market basket by 2021. The proposal would authorize the Secretary to make other budget neutral hospice payment system changes. Estimated savings of $9.3 billion over ten years.

• **Increase Income Related Premiums Under Medicare Parts B and D.** Similar to a proposal last year, beginning in 2020, the proposal would restructure income-related premiums under Medicare Parts B and D by increasing the applicable percent for calculating the lowest income-related premiums by five percentage points, from 35 percent to 40 percent of program costs, and creating new tiers at 52.5 percent, 65 percent, 80 percent, and 90 percent. Estimated savings of $41.1 billion over ten years.

• **Critical Access Hospitals (CAH) Reimbursement.** Medicare currently pays CAHs 101 percent of reasonable costs. The proposal would reduce this rate to 100 percent beginning in 2017. Estimated savings of $1.7 billion over ten years.
**Medicare Advantage**

- **Reform Medicare Advantage Payments to Improve Efficiency and Sustainability.** The President’s Budget would establish a new competitive bidding process in Medicare Advantage (MA) by revising the methodology used for the benchmark calculation. The Secretary currently determines a plan’s payment by comparing its bid to a benchmark. A benchmark is the maximum amount the federal government will pay for providing Part A and B covered services in the plan’s service area. A bid is the plan’s estimated cost of providing Medicare-covered services (excluding hospice, but including the cost of medical services, administration, and profit). If a plan’s bid is less than the benchmark, its payment equals its bid plus a rebate. The Budget proposes that the Secretary calculate an adjusted benchmark as the lesser of the current law fee-for-service benchmark (described above) or the average MA plan bid plus a 5 percent “buffer” to protect beneficiary rebates. This revised methodology is intended to incentivize plans to lower their bids in order to increase the likelihood of receiving a rebate. If passed, MA plans may experience increased pressure to reduce costs, which may result in provider reimbursement rate cuts/freezes or reduced lengths of stay. Plan advocates will likely oppose the proposed methodology. Additionally, the President’s Budget proposes to reduce inequities in quality bonus payments across counties by eliminating “benchmark caps” — ceilings based on 2010 county benchmarks — that affect counties with spending growth higher than the national average, and double bonuses, which allow some counties to receive double quality bonuses if they are located in metropolitan areas with at least 250,000 individuals. This proposal reinforces the Medicare Payment Advisory Commission (MedPAC) recommendations that were approved in January 2016. Together, these proposals are expected to result in savings of $77.2 billion over 10 years.

- **Expand the Ability of Medicare Advantage Organizations to Pay for Services Delivered via Telehealth.** The President’s Budget grants the Secretary discretion to expand the ability of MA plans to deliver medical services via telehealth by waiving certain Part B requirements that certain covered services be provided solely through face-to-face encounters. While it is unclear which specific services would be eligible for telehealth and the decision to utilize the telehealth benefit would remain at the discretion of the beneficiary, this proposal could potentially encourage MA plans to shift beneficiaries back to home or other community-based setting sooner than current practice. This proposal is expected to result in $160 million in savings over 10 years.

**Office of Medicare Hearings and Appeals (OMHA)**

To improve the efficiency of the Medicare appeals system and reduce the backlog of appeals awaiting adjudication at OMHA, HHS has developed a comprehensive strategy that involves additional funding, administrative actions, and legislative proposals.

- **OMHA Funding.** The FY2017 Budget request is $250 million (an increase of $143 million over FY2016). The Budget request includes a legislative package to address the growing backlog of Medicare appeals. HHS estimates that enactment of this package will provide an additional $125 million in Recovery Audit collections and $5 million from a proposed refundable filing fee.
The additional funding will allow OMHA to open new field offices in addition to the five current field offices in Florida, Ohio, California, Missouri, and Virginia, and also to hire additional adjudicators and support staff. OMHA will continue to utilize technology, such as video telephone and teleconference hearings, to offer appellants access to multiple hearing venues and services.

- **Legislative Package.** The budget proposes a legislative package aimed at both helping the Department process a greater number of appeals and reducing the number of appeals that reach OMHA including:
  
  - **Establish a Refundable Filing Fee.** This proposal institutes a refundable filing fee for Medicare Parts A and B appeals for providers, suppliers, and State Medicaid agencies, including those acting as a representative of a beneficiary, and requires these entities to pay a per-claim filing fee at each level of appeal. Fees will be returned to appellants who receive a fully favorable appeal determination. No budget impact.
  
  - **Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount in Controversy Threshold.** This proposal allows the OMHA to use Medicare magistrates for appealed claims below the federal district court amount in controversy threshold ($1,500 in calendar year 2016 and updated annually), reserving Administrative Law Judges (ALJs) for more complex and higher amount in controversy appeals. No budget impact.
  
  - **Expedite Procedures for Claims with No Material Fact in Dispute.** This proposal allows OMHA to issue decisions without holding a hearing if there is no material fact in dispute. No budget impact.
  
  - **Increase Minimum Amount in Controversy for ALJ Adjudication of Claims to Equal Amount Required for Judicial Review.** This proposal increases the minimum amount in controversy required for adjudication by an ALJ to the Federal Court amount in controversy requirement ($1,500 in calendar year 2016). No budget impact.
  
  - **Remand Appeals to the Redetermination Level with the Introduction of New Evidence.** This proposal remands an appeal to the first level of appeal when new documentary evidence is submitted into the administrative record at the second level of appeal or above. Exceptions may be made if evidence was provided to the lower level adjudicator but erroneously omitted from the record, or an adjudicator denies an appeal on a new and different basis than earlier determinations. No budget impact.
  
  - **Sample and Consolidate Similar Claims for Administrative Efficiency.** This proposal allows the HHS Secretary to adjudicate appeals through the use of sampling and extrapolation techniques. Additionally, this proposal authorizes the HHS Secretary to consolidate appeals into a single administrative appeal at all levels of the appeals process. Parties who are appealing claims included within an extrapolated overpayment or consolidated previously will be required to file one appeal request for any such claims in dispute. No budget impact.
Medicaid Program (Legislative Unless Noted Otherwise)

Medicaid Home and Community-Based Services

- **Pilot Comprehensive Long Term Care State Plan Option.** Eight-year pilot program which would create a comprehensive long term care state plan option for up to five states. Participating states would be authorized to provide home and community-based care at the nursing facility level of care, creating equal access to home and community-based care and nursing facility care. The Secretary would have the discretion to make these pilots permanent at the end of the eight years. The effort would cost $4.1 billion over 10 years.

- **Expand Eligibility Under the Community First Choice Option.** This proposal would provide states with the option to make medical assistance available to individuals who would be eligible under the state plan if they were in a nursing facility. Under current law, any state interested in the Community First Choice Option must create or maintain a 1915(c) waiver with at least one waiver service to make the benefit available to the special income group or provide eligibility for the Community First Choice benefit through another eligibility pathway. This approach is administratively burdensome for states. This proposal would provide equal access to services under the state plan option and provide states with additional tools to manage their long term care home and community based service delivery systems. The proposal would cost $3.9 billion over ten years.

- **Allow States to Develop Age-Specific Health Home Programs.** This proposal would allow states to target their Health Home programs by age. Currently, states are required to cover Health Home services for all categorically needy individuals with the specified chronic condition(s), regardless of age. Many states have voiced support for allowing age-specific targeting of their Health Home model to better serve the needs of youth with chronic conditions. The initiative would cost $1.1 billion over ten years.

- **Allow Full Medicaid Benefits for Individuals in an HCBS State Plan Option.** This proposal would allow states to target their Health Home programs by age. Currently, states are required to cover Health Home services for all categorically needy individuals with the specified chronic condition(s), regardless of age. Many states have voiced support for allowing age-specific targeting of their Health Home model to better serve the needs of youth with chronic conditions. This proposal would provide states with the option to offer full Medicaid eligibility to medically needy individuals who access home and community-based services through the state plan option under section 1915(i) of the Social Security Act. Currently, when a state elects to not apply the community income and resource rules for the medically needy, these individuals can only receive 1915(i) services and no other Medicaid services. This option would provide states with more opportunities to support the comprehensive health care needs of individuals with disabilities and the elderly. The proposal is estimated to cost $9 million over ten years.
• **Expand Eligibility for the 1915(i) HCBS State Plan Option.** This proposal would increase states’ flexibility in expanding access to home and community-based services under section 1915(i) of the Social Security Act. Currently, certain non-categorically eligible individuals who meet the needs-based criteria can only qualify for home and community-based services through the 1915(i) state plan option if they are also eligible for home and community-based services through a waiver program. This proposal removes this requirement, which will reduce the administrative burden on states and increase access to home and community-based services for the elderly and individuals with disabilities. The proposal would cost $374 million over 10 years.

**Medicaid Managed Care**

• **Require Remittances for Medical Loss Ratios for Medicaid and CHIP Managed Care.** The President’s Budget grants CMS the authority to apply a medical loss ratio (MLR) of 85 percent to Medicaid managed care plans. The proposal also includes a requirement that states collect a remittance of any amounts spent in excess of the MLR and return the federal share to the federal government. Together, these changes are expected to result in $23.5 billion in savings over 10 years. This proposal aligns with Medicare Advantage and Health Insurance Marketplace requirements and reinforces CMS’s efforts to apply an MLR to Medicaid managed care plans as discussed in the Medicaid managed care Proposed Rule. If passed, this proposal would help reinforce CMS efforts to ensure that a certain portion of plan funds are used for health care services (including provider reimbursement) and quality improvement efforts as opposed to plan administration and profit.

• **Strengthen CMS Compliance Tools in Medicaid Managed Care.** This budget-neutral proposal would provide CMS maximum flexibility to disallow and defer individual payments or partial payments associated with contracts with Medicaid managed care plans. Specifically, this proposal allows CMS to modify deferrals and disallowances to address the severity and scope of violations, similar to the authorities in fee-for-service Medicaid. While this proposal does not have a direct impact on providers, it could improve efforts related to plan accountability and federal oversight.

**Dual Eligible Efforts**

• **Integrating Care for Duals.** The FY2017 President’s Budget includes a series of legislative proposals to improve access to care for dual-eligible beneficiaries, while reducing the administrative inconsistencies between the Medicare and Medicaid programs. Proposals include: 1) creating an integrated appeals process for dual-eligible beneficiaries (budget neutral), 2) modifying definitions for countable income and assets for determining eligibility for receiving Medicare Savings Program benefits to align with those used to determine eligibility for Part D Low-Income Subsidies ($394 million in Medicaid costs over 10 years), and 3) coordinating review of dual-eligible special needs plans marketing materials (budget neutral). If passed, these efforts may help eliminate administrative inconsistencies across programs.
Program Integrity

In FY2017, the budget proposes $199 million in new mandatory and discretionary investments to address healthcare fraud, waste, and abuse with efforts for both Medicare and Medicaid. These program integrity investments will yield $23.8 billion in savings for Medicare and Medicaid over 10 years, according to the government. The budget also proposes legislative changes which would give DHHS important new tools to enhance program integrity oversight and cut fraud, waste, and abuse in the Medicare and Medicaid programs.

- **Health Care Fraud and Abuse Control Funding (HCFAC).** The budget proposes to build on recent Integrity successes by increasing support for HCFAC through both mandatory ($1.3 billion — $45 million more from 2016) and discretionary ($725 million — $44 million more from 2016) funding streams. The mandatory funding is allocated to the Medicare Integrity Program, the HCFAC account (divided between HHS OIG and other HHS agencies), the US Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). These dollars would fund comprehensive efforts to combat health care fraud, waste and abuse, including prevention-focused activities (e.g., improper payment reduction, provider education, data analysis, audits, investigations and enforcement). The discretionary funding is allocated to CMS Program Integrity activities ($487 million), DOJ ($116 million) and HHS, OIG ($122 million). Compared to 2016, more funds would go to HHS’ law enforcement partners to expand Strike Force capacity and support rigorous data analysis and increased focus on civil fraud.

- **Medicaid Integrity Program.** The Affordable Care Act (ACA) increased appropriations for the Medicaid Integrity Program for FY2011, and future years by inflation. The Medicaid Integrity Program plays an important role in supporting state efforts, including contracting with entities to carry out review, audits, identification of overpayment, education activities and technical support to the states.

- **New Tools for Combating Fraud and Abuse.** The ACA and subsequent legislation (The Patient Access and Medicare Protection Act) has allowed CMS to take actions to ensure that the correct payment is made to the right provider for the appropriate service. These tools include: enhanced provider screening; implementation of the Fraud Prevention System, which is a sophisticated predictive analytics tool; the expansion of prior authorization in Medicare fee-for-service (FFS) and the removal of Social Security numbers from Medicare cards; new flexibility to the Medicaid Integrity Program; and funds earmarked for the Medicare-Medicaid data match program, which will allow CMS to enhance collaborative efforts between Medicare and Medicaid to fight fraud, waste and abuse.

- **Medicare Strike Force.** The budget would allow HHS and DOJ to continue to strengthen the Strike Force presence across the country; using requested HCFAC funding to enhance efforts in existing Strike Force cities, and potentially expanding into new service areas based on data showing high incidences of fraud.
Legislative Proposals

Medicare - The budget proposes:

- Retain a Portion of Medicare RAC recoveries to implement actions that prevent fraud and abuse. This would allow additional funding for corrective actions above the amounts made available in the Reauthorization Act. The proposal would cost $2.5 billion and result in $3.3 billion in non-scorable savings over 10 years.

- Allow prior authorization for specified Medicare FFS Items and services. This would extend the authority to require prior authorization to all Medicare FFS items and services, particularly those that are at the highest risk for improper payment. The proposal would result in $75 million in savings over 10 years.

- Allow Civil Monetary Penalties (CMPs) for providers and suppliers who fail to update enrollment records. This proposal would penalize providers and suppliers for failing to update their enrollment records, providing an additional incentive to report up to date information and help reduce program vulnerability to fraud. The proposal would result in $32 million in savings over 10 years.

- Establish a registration process for clearinghouses and billing agents.

- Allow collection of application fees from individual providers and suppliers.

- Pay RAC after a Qualified Independent Contractor (QIC) decision on appealed claims.

- Require a surety bond or escrow account to cover overturned RAC determinations.

Medicaid - The budget proposes:

- Expand funding for the Medicaid Integrity Program. This proposal will be used to address additional program integrity vulnerabilities, including expansion of Medicaid Financial Management program reviews of state financing practices; critical updates to Medicaid claims and oversight systems needed to enhance auditing; technical assistance to state to address improper payments, and other efforts to assist states fight fraud, waste and abuse. The proposal increases the Medicaid Integrity Program by $580 million over 10 years.

- Require states to suspend Medicaid payments when the Secretary determines there is a significant risk of fraud. This proposal requires state Medicaid agencies to suspend payments to providers when the Secretary determines that the providers pose a significant risk of fraud to the Medicaid program, unless the state agency demonstrates that the benefits of continuing payments to the provider outweigh the risk of losses to fraud. The proposal has no budget impact.
• **Prevent use of federal funds to pay state share of Medicaid or CHIP.** This proposal will prevent states from using federal funds to pay the state share of Medicaid or CHIP, unless specifically authorized under law. The proposal has no budget impact.

*Medicare/Medicaid - The budget proposes:*

• **Protect Program Integrity algorithms from disclosure.** This proposal would protect anti-fraud and abuse algorithms developed for Medicare, Medicaid and CHIP from disclosure — allowing the Secretary and states to freely share algorithms developed through new predictive analytic tools. The proposal would result in $90 million in savings over 10 years.

• **Permit exclusion from federal health care programs if affiliated with sanctioned entities.** This proposal expands the current authority to exclude individuals and entities from federal health programs if they are affiliate with a sanctioned entity. The proposal would result in $70 million in savings over 10 years.