rapid growth of certain services. Effective calendar year 2018, this proposal seeks to encourage more appropriate use of ancillary services by amending 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 is clinically integrated and required to demonstrate cost containment, as defined by the Secretary. [$5.0 billion in savings over 10 years]

Provide Authority to Expand Competitive Bidding for Certain Durable Medical Equipment

Since implementation, the Competitive Bidding Program for durable medical equipment, prosthetics, and supplies has saved the Medicare program and beneficiaries billions of dollars by aligning payment amounts with market-based prices. Currently this program is restricted to certain categories of equipment, supplies and services. This proposal expands the competitive bidding program to additional categories, including: inhalation drugs, all prosthetics and orthotics, and ostomy, tracheostomy, and urological supplies. [$3.8 billion in savings over 10 years]

Encourage Appropriate Use of Inpatient Rehabilitation Facilities

This proposal adjusts 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 reinstitutes the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. [$2.2 billion in savings over 10 years]

Reduce Critical Access Hospital Reimbursements from 101 Percent of Reasonable Costs to 100 Percent of Reasonable Costs

Critical Access Hospitals are generally small, rural hospitals that provide their communities with access to basic emergency and inpatient care. Critical Access Hospitals receive enhanced cost-based Medicare payments (rather than the fixed-fee payments most hospitals receive). Medicare currently pays Critical Access Hospitals 101 percent of reasonable costs. This proposal reduces this rate to 100 percent beginning in 2017. [$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 2017, this proposal prevents facilities that are within 10 miles of another hospital from maintaining designation as a critical access hospital and receiving the enhanced rate. These facilities will instead be paid under the applicable prospective payment system. [$880 million in savings over 10 years]

Allow the Secretary to Determine Hospital Acquired Condition Reduction Program Penalty Amounts and Distribution

Beginning in FY 2018, the proposal provides authority to the Secretary to specify through regulation the amount, scoring and penalty payment calculation methodology, and distribution of penalties to be assessed to eligible hospitals participating in the Hospital Acquired Condition Reduction Program. The proposal is structured in such a way that the new program produces savings at least equivalent to the current reduction program. [No budget impact]

Clarify the Medicare Fraction in the Medicare Disproportionate Share Statute

This proposal clarifies that individuals who have exhausted inpatient benefits under Part A or who have elected to enroll in Part C plan should be included in the calculation of the Medicare fraction of hospitals' Disproportionate Share Hospital patient percentages. [No budget impact]

Modernize Funding for End Stage Renal Disease Networks

This proposal changes the withhold for the End Stage Renal Disease Networks from 50 cents to $1.50 per treatment, to be updated annually by the consumer price index. The withhold is deducted from each End Stage Renal Disease Prospective Payment System per-treatment payment, and has not been increased since 1986 when it first took effect. The End Stage Renal Disease Networks are currently underfunded to meet statutory and regulatory obligations. In order for the End Stage Renal Disease Networks to effectively and efficiently administer the future demands of the End Stage Renal Disease program, increased operational resources are required. [No budget impact]