

# PUBLICATION

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## Bipartisan Budget Act of 2018: Major Impacts on Health Care

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After a brief federal government shutdown overnight, Congress passed and the President signed into law the Bipartisan Budget Act of 2018 on February 9, 2018. The Senate voted 71-28 and the House voted 240-186 to approve the legislation. This major legislation provides for a two-year budget agreement that increases the budget caps, resulting in approximately \$300 billion in additional federal spending. The legislation increases both defense and domestic spending, suspends the federal debt ceiling until March 2019, and funds hurricane and wildfire disaster relief, among other programs. The measure extends stopgap funding through March 23, 2018 to keep the federal government fully operating and to give Congress time to enact a full-year omnibus appropriations measure for Fiscal Year 2018 (FY18).

The measure also extends and modifies dozens of health care programs, including extending funding for two years for community health centers and extending the Children's Health Insurance Program (CHIP) for an additional four years through FY27. Similar to the House-passed Continuing Resolution (CR) from earlier this week, the bill provides funding for a number of Medicare extenders and incorporates policy reforms from the CHRONIC Care Act and the Medicare Part B Improvement Act – affecting Stark Law compliance, physician payment plans, telehealth, home health services, and other programs. The bipartisan legislation also includes funding for the National Institutes of Health (NIH) and for efforts to combat the opioid crisis. Finally, the legislation repeals the Affordable Care Act's (ACA) Independent Payment Advisory Board (IPAB) and eliminates the Medicaid Disproportionate Share Hospital (DSH) reductions scheduled for FY18 and FY19. Of note, the legislation does not include ACA market stabilization measures to address ongoing uncertainty and turmoil in the individual insurance market.

### Background and Analysis

Key health care provisions included in the Bipartisan Budget Act of 2018 are outlined below.

### CHIP

- Extends funding for CHIP for four additional years (FY24 through FY27).
- Extends the Child Enrollment Contingency Fund, the Qualifying States Option, the Express Lane Eligibility option, and continues to require states to maintain eligibility levels for CHIP children through FY27.
- Extends funding for the pediatric quality measures program and requires states to report on a core set of pediatric quality measures, which had previously been optional.
- Extends funding for the outreach enrollment grants at \$48 million for FY24 through FY27 and allows a portion of the funds to be used for evaluation and technical assistance.

### Medicare Extenders

- Two-year extension of the Geographic Practice Cost Indices (GPCI) floor through December 31, 2019.
- Permanent repeal of the Medicare payment cap for therapy services beginning on January 1, 2018, and a lower threshold for the targeted manual medical review process from \$3,700 to \$3,000.

- Five-year extension of the 2-percent urban, 3-percent rural, and 22.6-percent super rural ground ambulance add-on payments until December 31, 2022. It would also require the Secretary of Health and Human Services (HHS), in consultation with stakeholders, to develop a data collection system for ambulance providers and suppliers to collect cost, revenue, utilization, and other information determined appropriate by the Secretary.
- Five-year extension of the Medicare low-volume hospital payments through September 30, 2022. Current low-volume payments would continue unchanged for one year through September 30, 2018. Modified payment adjustment based on total discharges would begin October 1, 2018. For FY19 through FY22, the low-volume adjustment standard would be set at 25 percent for hospitals with 500 or fewer total discharges, decreasing on a sliding scale to zero percent for hospitals with more than 3,800 total discharges.
- Five-year extension of the Medicare-dependent hospital (MDH) program through September 30, 2022.
- Two-year extension of funding for quality measure endorsement, input, selection, and reporting requirements, providing \$7.5 million per year in FY18 and FY19.
- Two-year extension of funding for outreach and education activities for Medicare beneficiaries, specifically for the State Health Insurance Programs (SHIPs), Area Agencies on Aging, Aging and Disability Resource Centers, and The National Center for Benefits and Outreach Enrollment.
- Five-year extension with reforms of the home health rural add-on until October 1, 2022. The reforms include a new methodology to target the add-on payment to those areas with a population density of six or fewer individuals per square mile.

## CHRONIC Care Act

- Extends and expands the Medicare Independence at Home demonstration by two years, increases the cap on participating beneficiaries from 10,000 to 15,000, and gives practices three years to generate savings against their spending targets.
- Allows providers to utilize telehealth for home dialysis patients beginning January 1, 2019.
- Permanently reauthorizes Medicare Advantage (MA) Special Needs Plans (SNPs) for vulnerable populations, along with a number of reforms to Dual-Eligible SNPs (D-SNPs) and Chronic Condition SNPs (C-SNPs) to improve care management.
- Expands the testing of the Center for Medicare & Medicaid Innovation (CMMI) Value-Based Insurance Design Model to allow MA plans in any state to participate in the model by 2020.
- Allows MA plans to offer a wider array of targeted supplemental benefits to chronically ill enrollees beginning in 2020.
- Allows MA plans to offer additional, clinically appropriate telehealth benefits in their annual bid amounts beyond the services that currently receive payment under Part B beginning in 2020.
- Provides Accountable Care Organizations (ACOs) the ability to expand the use of telehealth services.
- Expands the use of telehealth for individuals with a stroke beginning January 1, 2019.
- Allows Medicare ACOs the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. In addition, beneficiaries would have the option to voluntarily align to an ACO in which the beneficiary's main primary care provider is participating.
- Establishes a new voluntary ACO Beneficiary Incentive Program, which would allow certain two-sided risk ACOs to make incentive payments to all assigned beneficiaries who receive qualifying primary care services.
- Directs the Government Accountability Office to submit a report to Congress within 18 months that would provide information on the prevalence and effectiveness of Medicare and other payer medication synchronization programs.
- Requires the HHS Secretary to submit a report to Congress within 18 months that would evaluate long-term cost drivers to Medicare, including obesity, tobacco use, mental health conditions, and

other factors that may contribute to the deterioration of health conditions among individuals with chronic conditions.

- Requires the HHS Secretary to establish a process, beginning in plan year 2020, by which a Part D plan sponsor may submit a request to CMS for claims data under Parts A and B. These data, which would include claims as recent as possible, would be for the purposes of: optimizing therapeutic outcomes through improved medication use; improving care coordination as to prevent adverse health outcomes; and other purposes determined by the Secretary.

## Medicare Part B Improvement Act

- Creates a temporary transition service and education Medicare payment for home infusion beginning in 2019, remaining in place until the permanent benefit for home infusions previously established by Congress is implemented in 2021.
- Allows dialysis providers to seek outside accreditation, from organizations approved by Medicare, in order to be able to bill Medicare for end-stage renal disease (ESRD) services.
- Codifies the changes CMS made in regulations to streamline and clarify rules for providers regarding compliance with the Stark Law, including leases that were in violation and when signatures were required to document the terms of legal arrangements.
- Makes coverage of speech generating devices under durable medical equipment permanent under the Medicare program (removing the 2018 sunset under current law).
- Requires CMS to more rigorously enforce the requirement that durable medical equipment suppliers in the competition bidding program offer at least 50 percent of the diabetes test strip brands used by beneficiaries. Codifies and enhances the regulatory prohibition against suppliers unduly influencing beneficiaries to switch from their preferred brand of diabetes supplies.

## Child and Family Services and Supports Extenders

- Extends the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program at current-law level of \$400 million per year for FY18 through FY22. This program provides states, territories, and tribes with grants to support evidence-based home visiting programs for at-risk families.
- Allows HHS to continue to use Census Bureau data for states, making sure they use an appropriate alternative data source when determining funding for territories.
- Extends the Health Workforce Demonstration Project, which provides funding to help low-income individuals obtain education and training in high-demand, well-paid health care jobs, through FY19 at the current funding level.

## Public Health Programs

- Extends and increases mandatory funding for community health centers from \$3.6 billion per year to \$3.8 billion per year for FY18 and \$4 billion for FY19. Implements technical and programmatic changes.
- Provides \$3 billion per year in FY18 and FY19 to combat the opioid abuse problem, including enhanced state grants, public prevention programs, and law enforcement activities related to substance abuse and mental health programs.
- Provides \$1 billion per year in FY18 and FY19 for NIH research.
- Extends mandatory funding for the National Health Service Corps at the current level of \$310 million per year in FY18 and FY19.
- Extends and increases funding for the Teaching Health Center Graduate Medical Education Program from \$60 million per year to \$126.5 million per year in FY18 and FY19. Requires Congress to provide a report on the direct and indirect expenses associated with training residents at teaching health centers. Directs the Secretary of HHS to support the maintenance of filled positions at existing approved teaching health centers, as well as the expansion of existing or establishment of new such

programs, as appropriate. In awarding grants to establish new teaching health centers, this section also directs the Secretary to prioritize qualified teaching health centers that are located in a rural area or serve a health professional shortage area or a medically underserved community.

- Extends mandatory funding for the Special Diabetes Program for Type 1 Diabetes at the current level of \$150 million per year in FY18 and FY19, until expended.
- Extends mandatory funding for the Special Diabetes Program for Indians at the current level of \$150 million per year in FY18 and FY19, until expended.

## Miscellaneous Health Care Policies

- Repeals the IPAB that is charged with making recommendations that reduce Medicare spending when per-capita growth exceeds an expenditure growth target.
- Requires the HHS Secretary to reform the current home health payment system and implement a 30-day episode for payment, beginning January 1, 2020. This change is required to be budget neutral.
- Includes technical corrections to the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
- Extends the blended site neutral payment rate for certain long term care hospital discharges for two additional years through FY19.
- Permits physician assistants to serve as the attending physician to serve hospice patients, which allows them to manage and separately bill for hospice care.
- Allows physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs beginning January 1, 2024.

## Key health-related fiscal offsets to provide for the package are outlined below.

- Eliminates the Medicaid DSH reductions in FY18 and FY19, while maintaining the \$4 billion in reductions for FY20 and setting the amount of reductions for FY21 through FY25 at \$8 billion per year.
- Accelerates the closure of the Part D program coverage gap, known as the "donut hole," in which beneficiaries are responsible for a greater portion of their prescription drug costs. Decreases the beneficiary contribution to 25 percent of prescription costs in 2019, instead of 2020 under current law. In addition, increases the percentage that a drug manufacturer must discount the cost of prescription drugs from 50 percent under current law to 70 percent, with the drug plan responsible for five percent, starting in 2019.
- Changes Medicaid and CHIP's third-party liability requirements.
- Requires state Medicaid programs to count lottery winnings for determining an individual's income eligibility under Medicaid.
- Rescinds the \$985 million from the Medicaid Improvement Fund and the \$220 from the Medicare Improvement Fund.
- Modifies the Medicaid Drug Rebate Program for drugs that are line extensions of certain single source or innovator multiple source drugs. Specifically, clarifies that the rebate for line extensions of certain single source or innovator multiple source drugs is the greater of either the base rebate plus the additional rebate, or the base rebate plus the line extension rebate.
- Reduces pay for outpatient physical and occupational therapy services furnished by a therapy assistant to 85 percent of the rate that would have otherwise been paid.
- Reduces the amount that Medicare would otherwise pay for ambulance transports to and from a dialysis facility in non-emergency situations by 13 percent, in recognition of lower level of readiness associated with these routine, scheduled transports.
- Establishes a hospital transfer payment policy for early discharges to hospice care beginning October 1, 2018.

- Increases Medicare reimbursement for home health agency providers by 1.5 percent in 2020.
- Increases Medicare reimbursement for skilled nursing facility (SNF) providers by 2.4 percent in FY19.
- Sunsets the exclusion of biosimilars from the Medicare Part D coverage gap discount program by requiring manufacturers of biosimilars to provide a discount to remove the incentive to prescribe a brand reference biologic over the biosimilar.
- Increases the percentage that beneficiaries with a modified adjusted gross income of at least \$500,000 (\$750,000 for a couple filing jointly) pay in Medicare Part B and Part D premiums from 80 percent to 85 percent beginning in 2019. Freezes this new income threshold through 2028, at which point the threshold would be indexed to inflation.
- Reduces mandatory funding for the ACA's Prevention and Public Health Fund by \$1.35 billion over the ten-year budget window, to generate \$998 million in savings.