

# Issue Brief

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## The Bipartisan Budget Act of 2018: Analysis of Health Provisions *February 13, 2018*

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### Background

On February 9, 2018, [H.R. 1892, the “Bipartisan Budget Act of 2018,”](#) was signed into law. The \$320 billion budget deal includes short-term funding for the federal government through March 23, 2018, as well as full-year funding for the Department of Defense. The Senate approved the bill 71-28, and the House followed with a 240-186 vote. The agreement also provides for an increase in the debt limit, retroactively extends numerous expired tax breaks, provides \$89.3 billion in additional disaster aid, and extends and modifies dozens of health and family programs.

### *Health Provisions in the Budget Agreement*

Of note to ASHP members are modifications to numerous Medicare policies dealing with physician payment plans, telehealth, home health services, and other programs and procedures. The bill also permanently extends certain payment cap exemptions for outpatient therapy and permanently reauthorizes Medicare Advantage Plans for individuals with special needs. Finally, the bill extends funding for two years for Community Health Centers as well as funding for additional public health service programs, and it extends the Children’s Health Insurance Program for an additional four years, through FY 2027. A more comprehensive listing of the bill’s provisions follows.

#### Special Hospital Programs

- The measure extends the Low-Volume Hospital Program and the Medicare-Dependent Hospital program through Oct. 1, 2019, and requires MedPAC to examine the programs.

#### Rural Home Health

- The bill extends 3% add-on to payments made for home health services provided to patients in rural areas for five years, through Oct. 1, 2022.

#### Ambulance Add-Ons

- The agreement extends current Medicare reimbursement rates for ground ambulance service for five years, through Dec. 31, 2022.
- The most recent extension expired Jan. 1, 2018. Medicare adds 2% for urban ambulance payments, 3% for rural ambulance payments, and 22.6% for super rural ground ambulance payments.

### Medicare Work Geographic Adjustment

- Under current law, the Medicare fee schedule is adjusted to reflect the differences in the cost of providing services in different geographic areas, including by providing a payment floor in areas where labor costs are lower than the national average.
- The measure extends the 1.0 floor on the “physician work” cost index for two years, until Jan. 1, 2020.

### Outpatient Therapy Payments

- Medicare currently sets annual per-beneficiary payment caps for non-hospital outpatient therapy services, such as physical therapy, speech therapy, or occupational therapy.
- Providers can seek an exemption from the cap if the therapy is deemed medically necessary, but that exemption authority expired January 1, 2018.
- The measure permanently extends the authority to receive cap exemptions, retroactive to January 1, 2018.
- It also lowers from \$3,700 to \$3,000 the threshold at which the targeted manual medical review process must be implemented.

### Special-Needs Medicare Advantage Plans

- The measure permanently reauthorizes the availability of Medicare Advantage Plans to individuals with special needs. Under current law, special needs plans expire on January 1, 2019.
- These plans provide services for individuals with special needs, such as individuals who are institutionalized, individuals who are dually eligible for both Medicare and Medicaid, and individuals who are living with severe or disabling chronic conditions.
- Under the measure, special needs plans for individuals with severe or disabling chronic conditions must include in the interdisciplinary team some providers with experience in treating individuals similar to the targeted population.

### Access to Claim Data

- The agreement establishes a process under which a prescription drug plan sponsor can request data on the prescription drugs used by enrollees in the plan.
- Sponsors would be able to use this information to optimize therapeutic outcomes through improved medication use.
- Sponsors are prohibited from using the information to adversely impact beneficiaries or for marketing purposes.

### Merit-Based Incentive Payment System

- The Medicare Access and CHIP Reauthorization Act (MACRA) changed how Medicare pays physicians, repealing the sustainable growth rate (SGR) and replacing it with a quality-based system.

- The bill clarifies what services are covered under physician payments and extends transition time for certain provisions for an additional three years.
- Finally, it facilitates how the Physician-Focused Payment Model Technical Advisory Committee (PTAC) can develop additional physician-led payment models.

#### Medicare Advantage Plans

- Under current law, all Medicare Advantage (MA) plans must offer the same benefits to all of its beneficiaries; however, the Center for Medicare & Medicaid Innovations (CMMI) is testing a model that allows flexibility for an MA plan to meet the needs of chronically ill patients.
- The agreement expands the existing CMMI Value-Based Insurance Design Model to allow an MA plan in any state to participate, beginning Jan. 1, 2020, and it delays until Jan. 1, 2022, provisions regarding when to terminate the model.
- It allows an MA plan to offer additional supplemental benefits to chronically ill enrollees starting for 2020 plan years.
- Also starting in plan year 2020, MA plans could provide additional telehealth benefits, including benefits available under Medicare Part B and any additional telehealth benefits HHS determines to be appropriate.

#### Accountable Care Organizations

- The agreement allows certain accountable care organizations (ACOs) to make incentive payments of up to \$20 per service to assigned beneficiaries who receive qualifying primary services.
- The program would be voluntary, and participating ACOs would not receive additional funding.
- The measure allows ACOs in the Medicare Shared Savings Program to choose to have their beneficiaries assigned at the beginning of a performance year, and it allows beneficiaries to align to the ACO in which their primary care providers participate.

#### Home Health Services

- HHS is required to implement a budget-neutral payment for a 30-day episode of care.
- Beginning this year, HHS is authorized to use the medical records of home health providers and physicians to determine home health eligibility.

#### Independence at Home Medical Practice Demonstration Program

- The agreement includes a two-year extension to the Independence at Home Medical Practice Demonstration Program (IAH) and increases the cap on the demonstration from 10,000 to 15,000 practices.

### Expanding Telehealth

- Patients with end-stage renal disease (ESRD) who receive dialysis at home have the option to receive some of their monthly visits via telehealth instead of in-person.
- Patients must have in-person visits for the first three months during which they are enrolled in the ESRD program and four times a year after that.
- Patients presenting symptoms of a stroke may receive consultation via telehealth beginning in 2021, with none of the current geographic restrictions on where the physician is currently located.

### Third-Party Accreditation

- The agreement authorizes HHS to approve and use third-party accreditors of dialysis clinics and providers to reduce the backlog of facilities currently awaiting certification.
- HHS must begin accepting requests for approval from national accreditation bodies for accreditation of dialysis clinics and providers within 90 days of enactment.

### Transitional Payments

- The [21st Century Cures Act of 2016](#) allowed for reimbursement of the cost of services to administer drugs through home infusions beginning in 2021.
- The bill provides a transitional payment for home-infusion providers from 2018 until 2021 when payments under the 21st Century Cures Act kick in.
- These transitional payments are set at the rates in the Medicare physician fee schedule.

### Supervision Policies

- H.R. 1982 prevents Medicare from enforcing the direct supervision rules for outpatient therapy services at critical access hospitals (CAHs) and other small, rural hospitals.
- The bill also allows physician assistants to serve hospice patients beginning in 2018.
- Beginning in 2024, physician assistants, nurse practitioners, and clinical nurse specialists are eligible to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs.

### Medicare Studies and Reports

- HHS must submit a report to Congress within 18 months on the long-term cost drivers to Medicare, including obesity, tobacco use, mental health conditions, and any other contributing factors among individuals with chronic conditions.
- H.R. 1892 also requires the Government Accountability Office (GAO) to report to Congress within 18 months of enactment on prevalence of comprehensive longitudinal care planning, including any barriers, and the development of payment for a longitudinal care plan for Medicare recipients who are diagnosed with a serious or life-threatening illness.
- The GAO must also report on the prevalence and effectiveness of medication synchronization programs under payers, including Medicare.

- The GAO is required to study the prescribing practices, drug adherence, patient outcomes, and spending on obesity drugs under the Medicare program.

#### Community Health Centers

- Funding for Community Health Centers (CHCs), the National Health Service Corps (NHSC), and the Teaching Health Center Graduate Medical Education Program is extended for two years.
- Funding for health centers to participate in the All of Us Research Program, which encourages health centers to generate biomedical data research, is provided in 2018.
- The Health Resources and Services Administration (HRSA) is authorized to make supplemental awards to CHCs to improve the quality of services at these facilities, and to award grants for new health centers and expanded services, especially those treating the most underserved patients.

#### Children's Health Insurance Program

- The agreement authorizes the Children's Health Insurance Program (CHIP) for an additional four years, through FY 2027.
- The January bill that funded the government through February 8, 2018, extended CHIP for six years, through FY 2023.
- The Pediatric Quality Measures Program, which includes mandatory reporting in 2024, and the Outreach and Enrollment Grants Program, which identifies and enrolls CHIP-eligible children, are both extended through 2027.

#### Independent Payment Advisory Board Repeal

- The Affordable Care Act (ACA) created a 15-member Independent Payment Advisory Board (IPAB) to replace the Medicare Payment Advisory Commission (MedPAC), which makes non-binding recommendations to Congress regarding options to control Medicare spending.
- H.R. 1892 repeals the provisions of the ACA and preserves the MedPAC, including its non-binding recommendations to Congress.

#### Temporary Medicaid Relief for Puerto Rico and the Virgin Islands

- Similar to states, Puerto Rico and the U.S. Virgin Islands finance Medicaid jointly with the federal government, but at a greater percentage than states. Additionally, territories need to have their full share at the beginning of a fiscal year to receive a federal match. Unlike states, there is also a cap on how much federal match territories can receive on an annual basis.
- Due to the recent natural disasters in the Caribbean, Puerto Rico and the U.S. Virgin Islands will receive 100% of Medicaid funding through FY 2019, including an additional \$3.66 billion and \$107 million, respectively.

## Health Program Spending Offsets

To offset the cost of the bill's various healthcare funding extensions and other related provisions, H.R. 1892 includes a number of other provisions estimated by the Congressional Budget Office to generate \$38.5 billion over 10 years:

- The Prevention and Public Health Fund created by the ACA funds various activities such as vaccinations and education efforts. Congress has modified the funding for this program through 2027 to generate about \$1 billion in savings over 10 years.
- Under current law, individuals enrolled in Medicare Parts B and D pay a premium for these services, with premiums adjusted according to the individual's or couple's income, divided into four brackets. The bill adds a fifth bracket for the highest income beneficiaries, generating about \$1.6 billion in savings over 10 years.
- Under current law, lump-sum payments such as an inheritance, lottery winnings, or legal settlement are treated as income only in the month they are received. Individuals are eligible to reapply for Medicaid in subsequent months and not have the lump-sum payment qualify as income. The bill modifies that provision to include such lump-sum payments for a longer period of time. This is estimated to generate about \$475 million over 10 years.
- The bill modifies the calculation for setting the percentage a beneficiary pays for prescription drugs while in the coverage gap under Medicare Part D. Under the measure, beneficiaries would save money because the drug manufacturer must pick up more of the cost while beneficiaries are in the coverage gap. The federal government, meanwhile, saves money because the beneficiaries take longer to reach their annual out-of-pocket spending limit.
- Hospitals will receive a lower payment for short-stay hospital payments transferred to hospice, generating about \$5 billion in savings over 10 years.
- All available funds currently held in the Medicare Improvement Fund are eliminated, and all unobligated funds under the Medicaid Improvement Fund are rescinded for a total of \$1.3 billion in savings.
- Payment for Medicare Part B therapy services provided by a physical and occupational therapy assistant will be paid at 85% of the physician fee schedule, resulting in \$1.2 billion in savings.
- Scheduled reductions for Medicaid disproportionate share hospitals (DSHs) for FY 2018–19 are eliminated for an estimated savings of \$185 million.
- Under current law, innovator biologics pay a 50% discount when within the Part D coverage gap. H.R. 1892 would require that biosimilars be subject to the same 50% discount program, thereby incentivizing patients to choose lower-cost biosimilars and saving the Medicare program about \$10 billion over 10 years.
- The budget agreement saves \$5.7 billion through modifications to the Medicaid manufacturer rebate calculation.
- The single conversion factor under the physician fee schedule is reduced from 0.5% to 0.25% in 2019, saving almost \$2 billion.

- The home health market basket and the skilled nursing facility market basket updates are reduced by 1.5% and 2.4%, respectively, realizing about \$5.4 billion in savings.
- CMS would be allowed to calculate an enrollment-weighted average of the five-star quality rating if one or more plans is consolidated by an insurer, resulting in a potential \$520 million in savings.
- Finally, there are two non-health-related provisions related to child support fees and incentive programs for prison data reporting that would save less than \$300 million over 10 years.

### Impact on ASHP Members

While there are no direct provisions focusing on pharmacists or pharmacy, there are potential opportunities created in H.R. 1892 to expand access to care in rural areas and populations with chronic conditions. We will continue to work with CMS and HHS as they begin to implement the provisions of the act to ensure that these changes are made in a way that best serves patients.

### Resources

1. Fact Sheet No. 115-15, H.R. 1892, *Congressional Quarterly House Action Reports*, February 8, 2018.
2. The Bipartisan Budget Act of 2018 (H.R. 1892)  
<https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892eah.pdf> (accessed on February 9, 2018).

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