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M E M O R A N D U M

TO: All Members

FROM: Dan Heim, Executive Vice President

DATE: February 20, 2018

SUBJECT: **Bipartisan Budget Act of 2018**

ROUTE TO: Administrator, Program Directors, Department Heads

ABSTRACT: Detailed summary of health and LTC provisions in federal budget.

Introduction

The Bipartisan Budget Act of 2018 (P.L. 115-123) ("The Act") was passed by Congress and signed into law by President Trump on Feb. 9th, ending a brief federal government shutdown. The two-year budget agreement covering Federal Fiscal Year (FFY) 2018 (the current year) and FFY 2019 includes funding to operate the federal government until March 23, 2018.

The law includes significant health care policy changes impacting Medicare and Medicaid and other federal health programs. In addition to raising the federal spending caps in the Budget Control Act of 2011 by about $300 billion over two years, this budget legislation authorizes additional spending for health care priorities. However, the Act continues sequestration cuts and includes other reductions to Medicare provider reimbursements.

Of the $300 billion increase, the limit on military spending is increased by $80 billion in the current fiscal year and $85 billion in FFY 2019, which begins Oct. 1. The limit on nondefense spending increases by $63 billion this year and $68 billion next year, including added funding for infrastructure, the opioid crisis and mental health, child care and veteran's hospitals and clinics. In addition, the legislation authorizes nearly $90 billion in disaster relief in response to last year's hurricanes and wildfires.

The Act also lifts the U.S. public debt limit until March 2019, deferring any future action on that issue until after the mid-term Congressional elections. The budget package will keep federal

agencies open until March 23, giving the House and Senate Appropriations Committees time to develop a $1.3 trillion omnibus spending bill that will fund federal agencies through Sept. 30, 2018, the end of the current fiscal year.

The Trump Administration released a proposed $4.4 trillion budget for the next fiscal year on Feb.12th, which includes large cuts to domestic programs and increases in military spending. The plan contains at least $1.8 trillion in cuts to federal entitlement programs including Medicaid, Medicare and food stamps. The LeadingAge website provides more details on the Administration's budget proposal and how it would affect long term care providers and affordable housing. However, the President's budget was developed before the Bipartisan Budget Act of 2018 was enacted, and most observers currently believe that the blueprint has little or no chance of being adopted. Nonetheless, LeadingAge NY and other advocates will continue to strongly oppose any efforts to advance damaging proposals such as Medicaid block grants or per capita funding caps.

The Act renews several expired Medicare programs, makes several Medicare policy changes, and codifies "Stark Law" changes. It also repeals the establishment of the Independent Payment Advisory Board, and maintains the current non-binding Medicare Payment Advisory Commission (MedPAC) spending review process.

Of specific importance to New York and its state budget, the Act: (1) extends the Children's Health Insurance Program (CHIP) for an additional four years (through FY 2027) on top of the six-year authorization included in the last continuing budget resolution; and (2) eliminates the reductions in Medicaid Disproportionate Share Hospital (DSH) allotments for hospitals in FFY 2018 and FFY 2019, but maintains the $4 billion in reductions for FFY 2020. The amount of reductions for FY 2021 through FY 2025 is set at $8 billion per year.

The balance of this memo provides an overview of the major health and long term care related provisions of the Bipartisan Budget Act of 2018.

Payment Updates to Medicare Rates

The Act extends existing cuts and increases reductions to Medicare payment updates for providers to pay for other provisions. It continues the sequestration of mandatory spending for FFY 2018 and FFY 2019, including the two-percent cut to Medicare skilled nursing facility (SNF) and home health agency (HHA). It also extends mandatory sequestration for an additional two years, through FFY 2027. Providers are reminded that the 2 percent cut under sequestration is made following calculation of the provider's Medicaid rate under the relevant methodology.

The Medicare market basket (inflationary) update to SNF rates will be limited to 2.4 percent in FFY 2019, which represents a decrease from the 2.7 percent update which was forecasted. The market basket update for HHAs will be set at a reduced level of 1.5 percent for FFY 2020. The physician fee schedule update for 2019 is reduced from 0.50 percent to 0.25 percent.

Other Revisions to HHA Payments

The Act makes other revisions to HHA payments:

- ***30-day episode.*** The Centers for Medicare and Medicaid Services (CMS) would be required to reform the current HHA Prospective Payment System (PPS), beginning January 1, 2020, to replace the current 60-day unit of payment in the PPS to a 30-day

payment episode. The change will be made on a budget-neutral basis (meaning that it will not result in a payment reduction to providers). This change to a 30-day episode is consistent with the Home Health Groupings Model (HHGM) proposed by CMS for implementation in Calendar Year (CY) 2019. While the change to the 30-day episode is budget neutral, other aspects of the HHGM would result in changes to the level of Medicare payments to agencies.

- ***Case-mix classification.*** The Act also requires CMS to convene a technical expert panel during CY 2018 to make recommendations on how to adjust for case-mix in the HHA PPS, with a report issued to Congress by April 1, 2019. The group will examine the HHGM and other case-mix approaches. CMS is required to issue a proposed rulemaking for comment on a case-mix classification system by Dec. 31, 2019.
- ***Rural add-on.*** LeadingAge NY is pleased that the Bipartisan Budget Act also extends the home health rural add-on. However, the level of payment and effective period will vary based on the number of episodes and population density in each rural area. For those rural areas with the highest number of home health episodes per 100 beneficiaries, the add-on will be 1.5 percent in 2019 and 0.5 percent in 2020; for rural areas with very low-population density, the add-on will start at 4 percent in 2019 and decrease by one percent per year through 2022; and for remaining rural areas the add-on will start at 3 percent in 2019 and decrease by one percent per year through 2021. By Jan. 1, 2023, the Inspector General of the Department of Health and Human Services is to report to Congress on the impact of the additional payments on access to home health services in rural areas.
- ***Medical necessity.*** The Act provides some relief on documentation of eligibility for Medicare coverage of HHA services. Effective Jan. 1, 2019, it allows CMS to use documentation in the medical record of the HHA as the supporting material, instead of also requiring use of documentation in the medical record of the physician who certifies eligibility or the medical record of the acute or post-acute care facility from which the patient was admitted to home health care. LeadingAge NY has long advocated for relief from HHA Face-to-Face and other eligibility requirements.

Repeal of Therapy Caps

Effective Jan. 1, 2018, the Act permanently eliminates the hard cap on how much outpatient physical therapy (PT), speech therapy (ST) and occupational therapy (OT) each Medicare beneficiary is allowed per year. LeadingAge NY has been advocating for this repeal for many years, and is pleased that it has finally occurred. Congress had allowed an exceptions process for the caps over most of the last 20 years this provision has been in place, but the Act repeals the caps and replaces them with a more flexible targeted medical review threshold of $3,000 for OT and a separate $3,000 threshold for PT and ST combined.

The Act would continue to require that an appropriate modifier (i.e., KX) be included on claims over the current exception threshold (i.e., $2,010) indicating that the services are medically necessary, and it would lower the threshold for the targeted manual medical review process from $3,700 to $3,000.

Payment for Outpatient Therapy Assistant Services

Effective Jan. 1, 2022, the Act requires that Medicare Part B will pay for therapy services furnished all or in part by a physical and occupational therapy assistant at 85 percent of the rate that would have otherwise been paid for a physician. The therapy assistant must be acting within state licensure and consistent with Medicare supervision requirements.

CHRONIC Act Provisions

The Bipartisan Budget Act of 2018 incorporates the provisions of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which passed the Senate in 2017, including:

- ***Making the authority for Medicare Advantage Special Needs Plans (SNPs) permanent.*** SNPs can target enrollment to one or more types of individuals including: (1) institutionalized individuals (I-SNPs), (2) dually eligible low-income Medicare beneficiaries who also are eligible for Medicaid (D-SNPs); and (3) individuals with severe or disabling chronic conditions (C-SNPs). The legislation permanently authorizes SNPs if certain additional policy requirements are met that are aimed at improving care management in D-SNPs and C-SNPs. Rather than expiring under current law on December 31, 2018, SNPs could continue enrolling qualifying Medicare beneficiaries if they adopt the requirements outlined in the Act.
- ***Increasing the flexibility of Medicare Advantage plans to offer a wider array of supplemental benefits to chronically ill enrollees beginning in 2020.*** Under current requirements, such supplemental benefits must be primarily health-related with the primary purpose to prevent, cure, or diminish an illness or injury. Under the Act, additional supplemental benefits could be offered to meet non-clinical needs, such as transportation, food, housing, counseling and alternative therapies.
- ***Extending the Independence at Home Demonstration.*** This program provides a home-based primary care benefit using physician- and nurse practitioner-directed teams to high-need Medicare beneficiaries with multiple chronic conditions, allowing them to avoid unnecessary hospitalizations, emergency room visits, and nursing home use. The Act increases the maximum length of an agreement with a medical practice under the demonstration from 5 to 7 years, effectively extending the demonstration by 2 years.
- ***Improving access to telehealth.*** Provisions include: (1) allowing Medicare beneficiaries undergoing home dialysis to receive required monthly clinical assessments by practitioners using telehealth services, beginning Jan. 1, 2019, in any geographic area; (2) allowing Medicare Advantage plans to offer additional, clinically appropriate, telehealth benefits beyond the services that currently receive payment under Part B beginning in 2020; (3) allowing certain Accountable Care Organizations (ACOs) to provide and receive payments for telehealth services beginning Jan. 1, 2020, without geographic limitations on originating sites and in beneficiaries' homes; and (4) eliminating the originating site geographic restrictions for telehealth services to evaluate an acute stroke, beginning Jan. 1, 2019.
- ***Studying longitudinal comprehensive care planning services.*** The Act requires the General Accounting Office (GAO) to study possible Medicare Part B coverage of a voluntary shared decision-making process furnished by a provider through an interdisciplinary team, including a conversation with Medicare beneficiaries who have received a diagnosis of a serious or life-threatening illness. GAO will study whether comprehensive longitudinal care planning services are provided to beneficiaries, whether there would be any duplication in payment for such services Medicare already pays for, and barriers to hospitals, SNFs, hospices, HHAs and other providers working with a Medicare beneficiary to engage in the care planning process.

Hospice Changes

The Act includes the following changes affecting hospice care:

- ***Recognizing attending physician assistants as attending physicians to serve hospice patients.*** Physician assistants play an important role in providing care for older adults, especially in rural areas. This provision, which takes effect Jan. 1, 2019, will improve access to hospice.
- ***Adding hospice, as a setting of care, to the existing post-acute care transfer policy.*** Under the policy, hospitals are paid less by Medicare when the hospital transfers a patient to a post-acute care setting following a short-stay in the hospital for certain types of diagnoses. Hospice would be added to the current list of post-acute care providers under this policy, which includes hospitals or distinct part hospital unit excluded from the inpatient hospital PPS, SNFs and HHAs. The policy would be effective for discharges on or after Oct. 1, 2018 where the patient falls into one of the top ten reimbursed hospital stays. MedPAC is required to study the effects of this change on hospital discharges to hospices and report to Congress by March 15, 2021.

Medicare Part D "Donut Hole"

The Act accelerates the closure of the Part D program coverage gap, known as the "donut hole" – under which Medicare beneficiaries are responsible for a greater portion of their prescription drug costs. The doughnut hole has been narrowing each year since the Affordable Care Act was enacted in 2010, and was scheduled to close in 2020, when beneficiaries would be expected to pay 25 percent of the cost of all their prescriptions while they were in the gap.

Under the Act, the doughnut hole will now close in 2019 instead, at which point Part D enrollees will pay 25 percent of the cost of all their prescription drugs from the time they enter the gap until they reach catastrophic coverage. The legislation also increases the percentage that a drug manufacturer must discount the cost of brand name drug costs in the gap from 50 percent under previous law to 70 percent.

Fraud and Abuse

The Act authorizes increases in civil and criminal penalties and sentences for federal health care program fraud and abuse. Many of these penalties were last updated 20 years ago. Civil penalties are generally doubled, including those applicable to kickbacks and retention of overpayments. Additionally, criminal fines for crimes involving federal health care penalties are doubled or quadrupled. Maximum sentences are doubled from 5 to 10 years for false statements and representations; false statement or representation with respect to conditions or operations of facilities; and excess charges.

The Act also updates the application of the "Stark" physician self-referral laws under Medicare. The "Stark" law prohibits physicians from referring Medicare beneficiaries to facilities in which they (or a close family member) have a financial stake, and by prohibiting that facility from billing for Medicare services performed under such a referral. CMS recently changed Stark law regulations relating to when leases violate of Stark law and when signatures are required to document the terms of legal arrangements. This section codifies the changes CMS made.

Other Health Provisions of Interest

The Act includes other provisions that may be of interest to LeadingAge NY members, including:

- ***Expanding access to home dialysis therapy.*** Currently, many patients receiving home dialysis treatments have technology in their homes that could be used for patient monitoring. However, previous law did not allow the use of telehealth for this purpose. The Act authorizes reimbursement of telehealth services for beneficiaries in their homes (or in a renal dialysis facility) beginning Jan. 1, 2019, and allows end stage renal disease care providers to use telehealth for home dialysis monitoring. This provision would allow for monthly clinical assessments via telehealth, provided the beneficiary receives face-to-face assessments for the first three months and quarterly thereafter.
- ***GAO study and report on improving medication synchronization.*** Individuals with chronic diseases often take multiple prescriptions that are prescribed by different clinicians at different times, requiring patients to obtain prescriptions at various times during the month. GAO is directed to study and issue a report within 18 months on whether alignment of dispensing could improve medication adherence, patient outcomes and patient satisfaction, and if there are barriers in Medicare to doing so.
- ***Providing flexibility for beneficiaries to be part of an ACO.*** The Act gives ACOs in the Medicare Shared Savings Program the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. It also gives Medicare beneficiaries the option to voluntarily participate in the ACO in which the beneficiary's main primary care provider is participating. The beneficiary would retain his or her freedom of choice to see any provider.
- ***GAO study and report on impact of obesity drugs on patient health and spending.*** Historically, Medicare Part D has not covered drugs used for weight loss or gain, or for cosmetic purposes. Some Medicare Advantage prescription drug plans can cover these drugs as a supplemental benefit. This section would direct the GAO to submit a report to Congress within 18 months that would provide information on the impact of the use of obesity drugs on patient health and spending.
- ***HHS study on long-term risk factors for chronically ill Medicare beneficiaries.*** The Act would require the Secretary of Health and Human Services 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 impact the health status of individuals with chronic conditions. The study would include barriers to collecting and analyzing the information needed to conduct this evaluation and make recommendations for removing such barriers.

Summary

Please contact me at dheim@leadingageny.org or 518-867-8383, ext. 128 with any questions on the contents of this memorandum.