THE BIPARTISAN BUDGET ACT OF 2018

AT A GLANCE

On Feb. 9, Congress passed and the President signed into law the Bipartisan Budget Act of 2018, a massive budget bill containing a number of priorities important to hospitals and health systems. In addition to funding the government until March 23, the bill also raises the debt ceiling and sets spending levels for the next two years, raising defense and domestic spending by about $300 billion. In addition, it extends the Medicare sequester for two additional years, through 2027.

Among other provisions, the bill delays $5 billion in Medicaid disproportionate share hospital (DSH) reductions scheduled for fiscal years (FY) 2018 and 2019; extends several Medicare payment adjustments that support access in rural communities; eases future electronic health record (EHR) regulatory burdens; and provides additional funding for disaster relief and the Children's Health Insurance Program (CHIP). In addition, accompanying the bill was a “Bipartisan Budget Agreement,” which outlines several priorities that Congress will pursue when funding the government beyond March 23. These priorities, which were not included in the actual bill text and are, therefore, not yet passed into law, include $6 billion in funding for combatting the opioid epidemic, $4 billion to improve Veterans Affairs hospital and clinic facilities, $2 billion to support additional scientific research at the National Institutes of Health and $20 billion to invest in infrastructure, including programs related to rural broadband.

Specific highlights in the law for hospitals and health systems include:

- Delaying the Medicaid DSH allotment reductions for FYs 2018 and 2019;
- Extending CHIP through Sept. 30, 2027;
- Extending the Medicare-dependent hospital program and enhanced low-volume adjustment through Sept. 30, 2022, and ambulance add-on payments through Dec. 31, 2022;
- Extending through FY 2019, the blended payment for site-neutral long-term care hospital cases;
- Permanently repealing the Medicare payment cap for outpatient therapy services;
- Reforming the home health prospective payment system beginning in calendar year 2020;
- Reducing payments to hospitals when a hospital discharges a patient to hospice care early in their stay, similar to the Centers for Medicare & Medicaid Services’ post-acute care transfer policy, beginning in FY 2019;
- Eliminating a requirement that the EHR Incentive Program have more stringent measures over time;
- Eliminating the geographic requirement under Medicare for the use of telehealth services for stroke patients, beginning in January 2019; and
- Repealing the Independent Payment Advisory Board.

Our Take:
This bill includes certain provisions that benefit the patients and communities served by America’s hospitals and health systems. Importantly, this bill delays for two years cuts to Medicaid DSH payments, which are critical to hospitals and health systems that care for our nation’s most vulnerable populations—children, the poor, the disabled and the elderly. We also are encouraged that the bill extends critical rural programs, including the ones mentioned above, which help keep vital care and service in rural America. The bill also takes steps to improve management of chronic diseases and makes positive changes for accountable care organizations. Finally, the bill extends funding for CHIP for an additional four years, yielding a decade of certainty for children’s health coverage.

Further Questions:
If you have questions, please contact AHA Member Relations at 1-800-424-4301.
# THE BIPARTISAN BUDGET ACT OF 2018

## TABLE OF CONTENTS

| Background | Supplemental Appropriations, Tax Relief, and Medicaid Changes Relating to Certain Disasters and Further Extension of Continuing Appropriations | 4 |
| BUDGETARY AND OTHER MEASURES | 4 |
| REVENUE MEASURES | 5 |
| HEALTH AND HUMAN SERVICES MEASURES | 5 |
| FUNDING EXTENSION OF CHIP | 5 |
| EXTENSION OF PEDIATRIC QUALITY MEASUREMENT PROGRAM | 5 |
| EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM THROUGH FY 2027 | 5 |
| EXTENDING THE WORK GPCI | 6 |
| REPEALING THE MEDICARE PAYMENT CAP FOR THERAPY SERVICES AND IMPLEMENTING A LIMITATION TO ENSURE APPROPRIATE THERAPY | 6 |
| MEDICARE AMBULANCE SERVICES | 6 |
| EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS | 6 |
| EXTENSION OF THE MDH PROGRAM | 7 |
| EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORESEMENT, INPUT AND SELECTION | 7 |
| EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS | 8 |
| EXTENSION OF HH RURAL ADD-ON | 8 |
| EXTENDING THE INDEPENDENCE AT HOME DEMONSTRATION PROGRAM | 8 |
| EXPANDING ACCESS TO HOME DIALYSIS THERAPY | 9 |
| PROVIDING CONTINUED ACCESS TO MA SNPS FOR VULNERABLE POPULATIONS | 9 |
| ADAPTING BENEFITS TO MEET THE NEEDS OF CHRONICALLY ILL MA ENROLLEES | 9 |
| EXPANDING SUPPLEMENTAL BENEFITS TO MEET THE NEEDS OF CHRONICALLY ILL MA ENROLLEES | 10 |
| INCREASING CONVENIENCE FOR MA ENROLLEES THROUGH TELEHEALTH | 10 |
| PROVIDING ACOS THE ABILITY TO EXPAND THE USE OF TELEHEALTH | 10 |
| EXPANDING THE USE OF TELEHEALTH FOR INDIVIDUALS WITH STROKE | 11 |
| PROVIDING FLEXIBILITY FOR BENEFICIARIES TO BE PART OF AN ACO | 11 |
| ELIMINATING BARRIERS TO CARE COORDINATION UNDER ACOS | 11 |
| GAO STUDY AND REPORT ON LONGITUDINAL COMPREHENSIVE CARE PLANNING SERVICES UNDER MEDICARE PART B | 12 |
| GAO STUDY AND REPORT ON IMPROVING MEDICATION SYNCHRONIZATION | 12 |
BACKGROUND

On Feb. 9, Congress passed and President Trump signed into law the Bipartisan Budget Act of 2018, a massive bill containing a number of priorities important to hospitals and health systems. Among its key provisions, the bill delays $5 billion in Medicaid disproportionate share hospital (DSH) reductions scheduled for fiscal years (FYs) 2018 and 2019; extends several Medicare payment adjustments that support access in rural communities; eases future electronic health record (EHR) regulatory burdens; and provides additional funding for disaster relief and the Children’s Health Insurance Program (CHIP). This advisory contains a summary of the law’s key provisions.

In addition, accompanying the bill was a “Bipartisan Budget Agreement,” which outlines several priorities that Congress will pursue when funding the government beyond March 23. These priorities, which were not included in the actual bill text and are, therefore, not yet passed into law, include $6 billion in funding for combatting the opioid epidemic, $4 billion to improve Veterans Affairs (VA) hospital and clinic facilities, $2 billion to support additional scientific research at the National Institutes of Health and $20 billion to invest in infrastructure, including programs related to rural broadband.

DIVISION B: SUPPLEMENTAL APPROPRIATIONS, TAX RELIEF, AND MEDICAID CHANGES RELATING TO CERTAIN DISASTERS AND FURTHER EXTENSION OF CONTINUING APPROPRIATIONS

This section includes nearly $90 billion in emergency supplemental appropriations to help states, communities, businesses and individuals respond and recover from recent disasters, including Hurricanes Harvey, Irma and Maria, and wildfires in California. In this funding, $4.9 billion will be provided to increase the current Medicaid federal funding caps for Puerto Rico and the U.S. Virgin Islands for two years, including program oversight requirements.

DIVISION C: BUDGETARY AND OTHER MATTERS

This section sets spending levels for the next two years, raising defense spending by $80 billion and domestic spending by $63 billion this year and $85 billion and $68 billion, respectively, in FY 2019. It also raises the debt ceiling until 2019. These changes are not paid for with any additional cuts in payments to providers, which had been a primary concern for the field; in the past, budget cap and debt ceiling legislation has included significant cuts to payments to hospitals and health systems.

Finally, this section extends the Medicare sequester for two years, through 2027, at its current level of 2 percent.
**DIVISION D: REVENUE MEASURES**

This section contains revenue measures, which will, among other things, extend various expiring tax provisions, such as the alternative motor vehicle credit for qualified fuel cell motor vehicles.

**DIVISION E: HEALTH AND HUMAN SERVICES MEASURES**

**TITLE I: CHIP**

**Funding Extension of CHIP through FY 2027** (Sec. 50101)
Saves $260 million over 10 years

This provision extends CHIP funding for four additional years (FYs 2024 – 2027), building on Congress’s previous six-year extension of funding (FYs 2018 – 2023) that was passed as part of in the January 2018 short-term continuing resolution. It also requires states to maintain eligibility levels for CHIP children through FY 2027 based on eligibility standards in place at the time the Affordable Care Act (ACA) was enacted. In addition, the section extends through FY 2027 the following CHIP related programs: Child Enrollment Contingency Fund for states with funding shortfall based on higher than expected enrollment; Qualifying States Option for states to receive the CHIP enhanced matching rate if the state expanded Medicaid coverage for children before CHIP was created; and Express Lane Eligibility Option, which allows states to use income eligibility information from other government programs in making initial Medicaid and CHIP eligibility determinations. **AHA supported legislation to extend the funding of CHIP and is pleased that this provision, along with the previous one, provide 10 years of stability for the program.**

**Extension of Pediatric Quality Measurement Program** (Sec. 50102)
Score included in estimate for Sec. 50101

This section extends the funding of the pediatric quality measure program authorized by the CHIP Reauthorization Act (CHIPRA) of 2009 through FY 2027. The CHIPRA requires the Centers for Medicare & Medicaid Services (CMS) to identify and publish an annual “core set” of pediatric quality measures that could be used in Medicaid programs. Starting in 2024, states would be required to report on the pediatric core set.

**Extension of Outreach and Enrollment Program through FY 2027** (Sec. 50103)
Score included in estimate for Sec. 50101

This provision extends funding for CHIP outreach and enrollment grants at $48 million for FYs 2024 through 2027. Allows a portion of grant funds to be used for evaluation and technical assistance.
TITLE II: MEDICARE EXTENDERS

Extending the Work Geographic Practice Cost Index (GPCI) floor (Sec. 50201)
Spends $955 million over 10 years

This section extends the floor on the Physician Fee Schedule (PFS) work GPCI through Dec. 31, 2019. Medicare’s PFS payment rates are based on three components: work relative value units (RVUs), practice expense RVUs and malpractice RVUs. Each of these three components is adjusted by a GPCI to account for geographic variation in the cost of practicing medicine in different areas of the country. The Medicare Improvements for Patients and Providers Act of 2008 first mandated a 1.00 “floor” for the work GPCI, such that areas with GPCIs less than the floor instead would be raised to a 1.00 level.

Repealing the Medicare Payment Cap for Therapy Services and Implementing a Limitation to Ensure Appropriate Therapy (Sec. 50202)
Spends $6.5 billion over 10 years

This section permanently repeals the Medicare payment cap for outpatient therapy services, including physical therapy, speech-language pathology services and occupational therapy, beginning Jan. 1, 2018. However, hospital outpatient departments (HOPDs) and other providers of therapy services still will be required to add a KX modifier to therapy claims over the current exception threshold ($2,010 in 2018) to indicate that the services are medically necessary. Finally, the provision lowers the threshold for targeted manual medical review to $3,000 from $3,700.

Medicare Ambulance Services (Sec. 50203)
Saves $155 million over 10 years

The bill extends the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – as well as the 22.6 percent “super rural” (defined as the lowest quartile of all rural counties by population density) ground ambulance add-on payment for five years through Dec. 31, 2022. It also requires 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.

Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-volume Hospitals (Sec. 50204)
Spends $1.8 billion over 10 years

This provision extends the enhanced low-volume payment adjustment through Sept. 30, 2022, with modifications. Specifically, for FY 2018, low-volume hospitals will continue to be defined as those that are more than 15 road miles from another comparable hospital and that have up to 1,600 Medicare discharges. Qualifying
hospitals will receive an add-on payment to their prospective payment system (PPS) rate that ranges from 25 percent for hospitals with 200 or fewer Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. However, for FYs 2019 through 2022, the discharge thresholds will be modified to 500 total discharges and 3,800 total discharges. Specifically, qualifying hospitals will receive an add-on payment that ranges from 25 percent for hospitals with 500 or fewer total discharges to no adjustment for hospitals with more than 3,800 total discharges.

The original, more restrictive definition of low-volume is still included in the statute, but has not applied for a number of years. However, absent further congressional action, on Oct. 1, 2022, the definition of low-volume will revert back to this definition, which requires qualifying hospitals to be more than 25 miles from a comparable hospital and have fewer than 800 discharges.

This section also requires the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress on the extension of this payment adjustment by March 15, 2022.

Extension of the Medicare-dependent Hospital (MDH) Program (Sec. 50205)
Spends $890 million over 10 years

The bill extends the MDH program for five years through Sept. 30, 2022. It also allows a hospital to be considered rural for purposes of MDH qualification if it is located in a state with no rural areas and meets certain other geographic criteria, such as being located in an area designated by the state as a rural area or being designated by such state as a rural hospital. The MDH program, established in 1987, helps support small, rural hospitals for which Medicare patients make up a significant percentage of their inpatient days or discharges. Specifically, to qualify as an MDH, the hospital must be located in a rural area, have no more than 100 beds, not be classified as a sole community hospital, and have at least 60 percent of inpatient days or discharges covered by Medicare. These hospitals receive the sum of their inpatient PPS rate, plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. No later than two years after the date of enactment, the Government Accountability Office (GAO) would be required to complete a study on the MDH program.

The AHA strongly advocated for continuation of the MDH program, which will help hospitals with a greater dependence on Medicare achieve greater financial stability, thus allowing them to better serve their communities. We will continue to urge Congress to make the MDH program permanent.

Extension of Funding for Quality Measure Endorsement, Input and Selection (Sec. 50206)
Spends $15 million over 10 years

This section appropriates $7.5 million for each of FYs 2018 and 2019 to the “consensus-based entity” (currently the National Quality Forum) with which CMS
must contract to endorse quality measures and to provide pre-rulemaking input on measures CMS is considering for its quality measurement and pay-for-performance programs. The section also includes new requirements to report to Congress on the work of the consensus-based entity, including what projects it has completed and how much money was expended. It also mandates a GAO study (due by August 2019) on how CMS uses the consensus-based entity.

**Extension of Funding Outreach and Assistance for Low-income Programs**  
(Sec. 50207)  
*S spends $75 million over 10 years*

This provision continues funding outreach and education activities for Medicare beneficiaries, including the State Health Insurance Assistance Program, area Agencies on Aging, Aging and Disability Resources Centers and the National Center for Benefits and Outreach Enrollment. The provision also directs the Administration for Community Living with HHS to report on states’ use of funding.

**Extension of Home Health (HH) Rural Add-on** (Sec. 50208)  
*S spends $375 million over 10 years*

This section extends the payment add-on for rural HH cases for five years through calendar year (CY) 2022. A rural add-on has been in effect since 2004 as authorized several times, most recently by the Medicare Access and CHIP Reauthorization Act (MACRA), which mandated a 3 percent add-on through Dec. 31, 2017. This bill extends the 3 percent add-on through CY 2018. However, from CY 2019 through CY 2022, the add-on will start to phase out, under several different schedules, with the amount ranging from 4.0 percent to 0.5 percent. The add-on amount and phase-out schedule applied to a particular case will depend on its county or population density (for rural areas). In addition, the bill directs the HHS Office of Inspector General (OIG) to submit to Congress a report by January 2023 that analyzes rural add-on payments by county and makes recommendations on whether the add-on should continue.

**Title III: Creating High-quality Results and Outcomes Necessary to Improve Chronic Care**

**Extending the Independence at Home Demonstration Program** (Sec. 50301)  
*S spends $23 million over 10 years*

This section extends Medicare’s Independence at Home demonstration program, which tests whether home-based primary care for chronically-ill patients can improve patient outcomes and satisfaction and lower costs to Medicare. This provision extends the length of the demonstration by two years, increases the cap on the total number of participating beneficiaries from 10,000 to 15,000 and gives primary care practices three years to generate savings.
Expanding Access to Home Dialysis Therapy (Sec. 50302)
No impact on spending

This section expands the ability of beneficiaries on home dialysis to receive required monthly clinical assessments to monitor their condition using telehealth, beginning Jan. 1, 2019. Specifically, it expands the number of originating sites from which the beneficiary can have a telehealth assessment with his or her clinician to include freestanding dialysis facilities and the patient’s home. It also eliminates any geographic restriction for all originating sites.

Providing Continued Access to Medicare Advantage (MA) Special Needs Plans (SNP) for Vulnerable Populations (Sec. 50311)
Spends $125 million over 10 years

This provision permanently authorizes SNPs that, absent the legislation, would have expired at the end of CY 2019. These plans are targeted to specific groups of Medicare beneficiaries, including Medicare-Medicaid dual eligibles (D-SNPs), beneficiaries with chronic conditions (C-SNPs), and beneficiaries who reside in institutions (I-SNPs). The provision also takes steps to improve the integration between the Medicare and Medicaid programs. For example, it tasks the Federal Coordinated Health Care Office within CMS as the primary point of contact for states to address misalignment issues, and directs the HHS secretary to develop unified grievances and appeals procedures. The provision also updates which conditions would enable an individual to enroll in a C-SNP, and directs the HHS secretary to implement other requirements to improve the coordination of care.

Finally, the provision requires a number of studies. It directs MedPAC and the Medicaid and CHIP Payment and Access Commission (MACPAC) to work together to evaluate SNP plan performance, including how SNPs compare to each other and other types of coverage, e.g., standard MA plans. The provision also directs the HHS secretary to evaluate whether SNP and MA plan performance can be measured at the plan level rather than the contract level. Finally, it directs the GAO to study and report on the interaction between D-SNPs and Medicaid.

Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees (Sec. 50321)
Spends $45 million over 10 years

CMS is currently testing the use of variable cost-sharing to help MA enrollees access the highest value care through the Value-based Insurance Design (VBID) model. The model is currently being tested in 10 states. This provision directs the HHS secretary to expand the testing to 25 states in 2019, and to open the model to plans in all states no later than Jan. 1, 2020.
Expanding Supplemental Benefits to Meet the Needs of Chronically Ill MA Enrollees (Sec. 50322)
No impact on spending

This provision permits MA plans, including SNPs, to offer a broader range of supplemental benefits for individuals with certain chronic conditions. These services must have a reasonable expectation of improving or maintaining the health or overall function of the beneficiary and do not necessarily need to be health benefits, e.g., personal care services. The provision also directs GAO to evaluate this provision.

Increasing Convenience for MA Enrollees through Telehealth (Sec. 50323)
Saves $80 million over 10 years

This provision allows plans to, for plan year 2020 and beyond, provide increased access to care through telehealth and include those costs in the plans' bid amounts. Plans must continue to provide access to such services through in-person visits and may not include associated capital and infrastructure costs in their bids. The HHS secretary must engage in rulemaking to implement this provision, including to solicit public input on the types of services that should be covered if delivered via telehealth.

Providing Accountable Care Organizations (ACOs) the Ability to Expand the Use of Telehealth (Sec. 50324)
Spends $50 million over 10 years

This section applies the Next Generation ACO telehealth waiver criterion to the Medicare Shared Savings Program (MSSP) Track 2 (if an ACO chooses prospective assignment and remains at two-sided risk), MSSP Track 3, and two-sided risk ACO models with prospective assignment that are tested or expanded through the Center for Medicare & Medicaid Innovation (CMMI), as determined by the HHS secretary. Specifically, this provision eliminates the geographic component of the originating site requirement under Medicare for the use of telehealth services, allows beneficiaries assigned to the approved MSSP and other ACOs to receive currently allowable telehealth services in the home, and ensures that MSSP and other ACO providers are allowed to only furnish telehealth services as currently specified under the PFS, with limited exceptions. These provisions take effect Jan. 1, 2020.

To be eligible for Medicare payment for telehealth services under this section, the beneficiary must be located at an originating site that is either one of the approved sites listed in Section 1834(m)(4)(C)(ii) of the Social Security Act¹ or the beneficiary’s home. Medicare will not provide a separate payment for the originating site fee if the service is furnished in the home.

¹ These sites include: (1) the office of a physician or practitioner; (2) a critical access hospital; (3) a rural health clinic; (4) a federally qualified health center; (5) a hospital; (6) a hospital-based or critical access hospital-based renal dialysis center; (7) a skilled nursing facility; and (8) a community mental health center.
This section also mandates a study as to its implementation due to Congress from the HHS secretary by Jan. 1, 2026.

**Expanding the Use of Telehealth for Individuals with Stroke** (Sec. 50325)
Spends $230 million over 10 years

This provision eliminates a geographic requirement under Medicare for the use of telehealth services for stroke patients, beginning in January 2019, permitting payment to physicians nationwide who furnish telestroke services. This provision will expand the ability of stroke patients to receive timely consultations through telehealth. However, the facility fee will not be made to new categories of originating sites unless the site meets previously existing requirements for originating sites (e.g., hospitals and critical access hospitals will receive the facility fee for these telehealth services, while new sites may not).

The AHA has repeatedly asked for the removal of geographic requirements so that patients outside of rural areas may benefit from telehealth services and is pleased that this bill will do so for stroke patients.

**Providing Flexibility for Beneficiaries to be Part of an ACO** (Sec. 50331)
Spends $50 million over 10 years

This section allows MSSP ACOs the choice to have their beneficiaries assigned prospectively at the beginning of the year, instead of having CMS select either prospective or retrospective beneficiary attribution on their behalves. This change allows ACOs to select the beneficiary assignment methodology that works best for their model of care. This provision also allows beneficiaries to voluntarily identify an ACO provider as their primary care provider and, thus, be aligned to the MSSP ACO in which the provider is participating. In addition, it requires the HHS secretary to establish a process by which beneficiaries are notified of their ability to make such an election, as well as the process by which they may change such election. The beneficiary would retain his or her freedom of choice to see any provider.

**Eliminating Barriers to Care Coordination under ACOs** (Sec. 50341)
Saves $54 million over 10 years

This section establishes the ACO Beneficiary Incentive Program. This new program creates a process that allows certain two-sided risk ACOs to make incentive payments to all assigned beneficiaries who receive qualifying primary care services. Eligible ACOs would be allowed to offer a flat payment, of up to $20 per qualifying service, directly to the beneficiary. This program is voluntary. These ACOs will not be provided additional Medicare reimbursement to cover the primary care incentive payment costs. Permitting this option under a two-sided risk model gives these ACOs an additional tool to achieve better health outcomes for beneficiaries – as well as produce cost savings for both the ACO and the Medicare program. President Obama’s FY 2017 budget contained a similar policy proposal. Additionally, this section requires HHS to conduct an evaluation of the
Beneficiary Incentive Program. The report must include an analysis of the impact of this program's implementation on expenditures and beneficiary health outcomes. A report to Congress is due no later than Oct. 1, 2023.

**GAO Study and Report on Longitudinal Comprehensive Care Planning Services Under Medicare Part B (Sec. 50342)**

*No impact on spending*

No later than 18 months after enactment, this provision requires GAO to submit to Congress a report with recommendations for legislative and administrative action on the establishment of a payment code for a visit for longitudinal comprehensive care planning services. The term “longitudinal comprehensive care planning services” is defined as a voluntary shared decision-making process that is furnished by an applicable provider through an interdisciplinary team and includes a conversation with Medicare beneficiaries who have received a diagnosis of a serious or life-threatening illness. To the extent such information is available, the study shall include an analysis of whether services similar to longitudinal comprehensive care planning services are furnished to Medicare beneficiaries. It will examine whether such services overlap or duplicate services covered under the hospice benefit as well as the chronic care management code, evaluation and management codes, or other codes that already exist under part B. The study also will include any barriers to hospitals and others to working with a beneficiary to engage in the care planning process, barriers to providers accessing the care plan and associated documentation, and stakeholder’s views on the need for the development of quality metrics with respect to longitudinal comprehensive care planning services. The stakeholder views are to include how the quality measures provide information on the goals, values and preferences of the beneficiary; the documentation of the care plan; services furnished to the beneficiary; and outcomes of treatment.

**GAO Study and Report on Improving Medication Synchronization (Sec. 50351)**

*No impact on spending*

This provision directs GAO to conduct a study on the extent to which Medicare Part D plans and private payers provide individuals receiving multiple prescriptions on the same day with medication counseling in the pharmacy and the outcomes of these programs.

**GAO Study and Report on Impact of Obesity Drugs on Patient Health and Spending (Sec. 50352)**

*No impact on spending*

This provision directs GAO to conduct a study on the use of prescription drugs to manage the weight of obese patients and the impact of covering such drugs on patient health and health care spending.
**HHS Study and Report on Long-term Risk Factors for Chronic Conditions among Medicare Beneficiaries** (Sec. 50353)
*No impact on spending*

This section requires the HHS secretary to submit a report to Congress within 18 months of the date of enactment that evaluates 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 in the Medicare population. This provision mandates that the study include an analysis of any barriers to collecting and analyzing information regarding cost drivers and how to remove any such barriers (including through legislation and administrative actions).

**Providing Prescription Drug Plans with Part A and B Claims Data to Promote the Appropriate Use of Medications and Improve Health Outcomes** (Sec. 50354)
*No impact on spending*

This provision directs the HHS secretary to make certain Medicare Parts A and B claims data available to Medicare Part D plan sponsors. Plan sponsors may use the data only to support efforts to improve health outcomes through better medication use, to improve care coordination or to meet another purpose approved by the HHS secretary. Plans cannot use the data for marketing purposes or coverage determinations, among other prohibited uses.

---

**Title IV: Part B Improvement Act and Other Part B Enhancements**

**Home Infusion Therapy Services Temporary Transitional Payment** (Sec. 50401)
*Saves $910 million over 10 years*

Starting Jan. 1, 2019, a temporary payment will be available for furnishing a drug or biologic that is infused through an item of durable medical equipment to a beneficiary in the home. This temporary payment will remain in place until the permanent benefit for home infusions, which was previously established by Congress, is implemented in 2021.

**Orthotist’s and Prosthetist’s Clinical Notes as Part of the Patient’s Medical Record** (Sec. 50402)
*No impact on spending*

This section requires that information provided by orthotists and prosthetists is considered when examining the medical necessity for orthoses or prostheses.
Independent Accreditation of Dialysis Facilities and Assurance of High-quality Surveys (Sec. 50403)
No impact on spending

This section would permit Medicare to grant deeming status to one or more accrediting bodies to review dialysis facilities for compliance with the conditions and requirements for a Medicare participating facility. The accrediting body’s work can be verified through validation surveys, periodic review of its survey processes and performance reviews.

Modernizing the Application of the Stark Rule under Medicare (Sec. 50404)
No impact on spending

This section modifies the Stark Law, including the laws relating to the signatures required on certain compensation agreements and the conditions under which holdover leases and personal services arrangements will not be considered illegal compensation arrangements. The AHA has long advocated for change to address these “technical violations.”

Making Permanent the Removal of the Rental Cap for Durable Medical Equipment under Medicare with Respect to Speech-generating Devices (Sec. 50411)
Spends $12 million over 10 years

The bill authorizes permanent Medicare coverage for speech-generating devices under “routinely purchased durable medical equipment,” as opposed to using the rental item classification that may disrupt beneficiary access in certain situations.

Increased Civil and Criminal Penalties and Increased Sentences for Federal Health Care Program Fraud and Abuse (Sec. 50412)
No impact on spending

This section would update both the civil and criminal penalties for fraud and abuse in federal health programs that have largely remained static over the past 20 years. The bill also increases civil and criminal penalties for fraud and abuse of federal health care programs, modernizing amounts that were last updated approximately 20 years ago.

Reducing the Volume of Future EHR-related Significant Hardship Requests (Sec. 50413)
No impact on spending

This section eliminated a clause in the Health Information Technology for Economic and Clinical Health (HITECH) Act that mandated more stringent measures over time in the EHR Incentive Program. AHA advocated for this relief for hospitals and critical access hospitals (CAHs) from Stage 3 Meaningful Use provisions that are challenging to meet and require use of immature technology standards.
Strengthening Rules in Case of Competition for Diabetic Testing Strips (Sec. 50414)

No impact on spending

This section requires CMS to enforce more rigorously 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. It also will codify and enhance the regulatory prohibition against suppliers unduly influencing beneficiaries to switch from their preferred brand of diabetes supplies.

TITLE V: OTHER HEALTH EXTENDERS

Spends $300 million over 10 years

This title extends family-support, abstinence-only education and other youth education programs.

TITLE VI: CHILD AND FAMILY SERVICES AND SUPPORTS EXTENDERS

Extension of Maternal, Infant and Early Childhood Home Visiting Programs (Secs. 50601-50607)

Spends $1.9 billion over 10 years

These provisions extend funding for Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV) through FY 2022. These programs provide states, territories and tribes with grants to support evidence-based early childhood home visiting programs to improve outcomes for at-risk families. In addition, in order to develop data standards for home visiting programs, states will be required to:

- conduct assessments that demonstrate that MIECHV is improving lives of families;
- conduct follow-up needs assessments; and
- prioritize high-risk communities.

States also would be allowed to use a portion of MIECHV grant funds for pay-for-home visiting services. HHS is instructed to develop an appropriate alternative data source when determining MIECHV funding for territories.

Extension of Health Workforce Demonstration Projects for Low-income Individuals (Sec. 50611)

Spends $164 million over 10 years

This provision extends the Health Workforce Demonstration Project that funds education and training for high demand, health care jobs for low-income individuals. Funding would be extended through FY 2019.
**TITLE VII: FAMILY FIRST PREVENTION SERVICES ACT**

Spends $544 million over 10 years

This title enables states to use federal funds to provide more effective support to children and families to prevent foster care placements.

**TITLE VIII: SUPPORTING SOCIAL IMPACT PARTNERSHIPS TO PAY FOR RESULTS**

Spends $90 million over 10 years

This title provides funding to pay for outcomes achieved through Social Impact Partnership projects, such as those to reduce homelessness or the number of repeat offenders in the criminal justice system. Under these projects, state and local governments would raise their own money and pay for a social service, then be repaid by the federal government if a rigorous, independent evaluation showed the service achieved the intended result.

**TITLE IX: PUBLIC HEALTH PROGRAMS**

*Extension for Community Health Centers (CHCs), the National Health Service Corps and Teaching Health Centers that Operate Graduate Medical Education (GME) Programs* (Sec. 50901)

Spends $8 billion over 10 years

CHCs. This section extends and increases funding for CHCs from $3.6 billion per year to $3.8 billion for FY 2018 and $4 billion for FY 2019. It also authorizes the HHS secretary to award supplemental grants to health centers for implementing evidence-based models that increase access to high-quality primary care, including those related to expanding the use of telehealth. In addition, this section aims to help ensure that CHCs are collaborating with other health care providers, such as local hospitals, to improve care coordination and reduce unnecessary hospitalizations and emergency department admissions.

National Health Service Corps. This section extends funding for the National Health Service Corps at the current level of $310 million for each of FYs 2018 and 2019.

Teaching Health Center GME (THCGME) Program. This section extends and increases funding for the THCGME program from $60 million per year to $126.5 million for each of FYs 2018 and 2019. This program supports new and expanded primary care medical and dental residency programs in community-based ambulatory patient care settings, such as Federally Qualified Health Centers.
This section also requires the HHS secretary to report to Congress on the number of patients and patient visits treated by residents in the program, as well the number of residents who go on to serve in rural areas, health professional shortage areas or medically-underserved communities. In addition, it calls for a report to Congress on the direct and indirect expenses associated with training residents at teaching health centers.

This section directs the HHS secretary 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 HHS secretary to prioritize those that are located in a rural area or serve a health professional shortage area or a medically underserved community.

**Extension for Special Diabetes Programs (Sec. 50902)**

*Spends $488 million over 10 years*

This section extends funding for the Special Diabetes Program for Type 1 Diabetes at the current level of $150 million for each of FYs 2018 and 2019, until expended. It also extends funding for the Special Diabetes Program for Indians at the current level of $150 million for each of FYs 2018 and 2019, until expended.

**TITLE X: MISCELLANEOUS HEALTH CARE POLICIES**

**HH Payment Reform (Sec. 51001)**

*No impact on spending*

Beginning in CY 2020, the bill makes two significant changes to the HH PPS. First, payment for HH services will be based on a 30-day unit of service, rather than the current 60-day unit; this change will be made in a budget-neutral manner. The bill directs the HHS secretary to determine the impact of this change, specifically, the difference between assumed behavior change and actual behavior change on estimated aggregate expenditures per year for 2020 through 2026. In addition, the HHS secretary is authorized to make permanent and temporary adjustments to the standard payment amounts on a prospective basis to account for increases or decreases in aggregate expenditures that are identified through these annual assessments. The bill also eliminates the use of therapy thresholds as a case-mix adjustment factor when calculating payments.

In addition, the bill requires the HHS secretary to convene at least one technical expert panel during 2018 to identify and prioritize recommendations on the HH PPS with respect to the case-mix model developed by CMS, called the HH groupings model, and alternative models. The recommendations of this panel shall be submitted to Congress by April 2019. Further, the HHS secretary is directed to pursue rulemaking on a case-mix system by December 2019.
Information to Satisfy Documentation of Medicare Eligibility for HH Services  
(Sec. 51002)  
Spends $20 million over 10 years

This section allows the HHS secretary to use documentation in the HH medical record as supporting material when considering a physician’s documentation that certifies or recertifies whether a patient requires home health services.

Technical Amendments to Public Law 114-10 (MACRA)  
(Sec. 51003)  
No impact to spending

This section makes several changes to the Merit-based Incentive Payment System (MIPS) mandated by MACRA:

- **Application of MIPS Payment Adjustments.** The section amends the MACRA legislation in several places so that MIPS’ payment adjustments will apply only to covered professional services starting in 2020, rather than items and services. One of the most important consequences of this change is that part B drug payments would no longer be factored into MIPS payment adjustments.

- **MIPS Cost Category Flexibility.** The section provides CMS with an additional three years (until the CY 2024 payment year) to raise the weight of the MIPS cost category to 30 percent of the total MIPS score. Cost measures will count as 10 percent of the MIPS total score for CY 2020, and this provision will allow CMS to keep the cost category weight as low as 10 percent through the CY 2023 payment year.

- **MIPS Performance Threshold Flexibility.** This section provides CMS an additional three years (until the CY 2024 payment year) to increase the MIPS “performance threshold.” The performance threshold is the total MIPS score above which clinicians get positive payment adjustments, and below which they receive negative adjustments. MACRA originally required CMS to use the mean or median total MIPS score starting with CY 2021 payments. However, this section allows CMS to increase the performance threshold to “ensure a gradual and incremental transition” to using the mean or median.

Lastly, this section makes minor modifications to the charge of the Physician-focused Payment Model Technical Advisory Committee (PTAC) to allow it to provide more detailed feedback on models submitted for review.

Expanded Access to Medicare Intensive Cardiac Rehabilitation Programs  
(Section 51004)  
Scoring included with that of Section 51008

The section expands access to intensive cardiac rehabilitation (ICR) programs for beneficiaries with stable, chronic heart failure and any future condition for which
cardiac rehabilitation is covered, unless the HHS secretary determines coverage is not supported by clinical evidence.

**Extension of Blended Site-neutral Payment Rate for Certain Long-term Care Hospital (LTCH) Discharges; Temporary Adjustment to Site-neutral Payment Rates** (Sec. 51005)
Saves $45 million over 10 years

The blended payment for site-neutral LTCH cases will be extended for two years and now will be applied to payments during cost reporting periods beginning in FYs 2018 and 2019. This 50/50 blended rate combines the LTCH PPS standard rate and LTCH site-neutral rate. To offset this cost, the FYs 2018 through 2026 market-basket update for site-neutral cases only will be reduced by 4.6 percent.

**Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients** (Sec. 51006)
Spends $260 million over 10 years

The bill permits physician assistants to serve as the attending physician for the purposes of managing and separately billing for hospice care. It also enables physician assistants to act as the attending physician to establish, and periodically review, the hospice plan of care to ensure care is provided pursuant to such plan of care. Finally, the bill clarifies that, as with nurse practitioners, physician assistants cannot certify or recertify hospice care for individuals.

**Extension of Enforcement Moratorium on Supervision Requirements for Outpatient Therapeutic Services in CAHs and Small Rural Hospitals for CY 2017** (Section 51007)
No impact on spending

This section extends the enforcement moratorium on the “direct supervision” requirements for outpatient therapeutic services furnished in CAHs and small, rural hospitals with 100 or fewer beds for CY 2017. CMS, in the CY 2018 outpatient PPS final rule, extended the moratorium for CYs 2018 and 2019 but did not include the remainder of 2017. The bill closes the gap so that hospitals are no longer at risk for enforcement actions.

**Allowing Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists to Supervise Cardiac, Intensive Cardiac, and Pulmonary Rehabilitation Programs** (Section 51008)
Spends $290 million over 10 years

This section revises current law requirements so that, beginning Jan. 1, 2024, physician assistants, nurse practitioners and clinical nurse specialists will be permitted to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs. Currently, only a physician may supervise such programs.

---

2 The scoring of Sec. 51004 is also included in this figure.
Transitional Payment Rules for Certain Radiation Therapy Services under the Physician Fee Schedule (Sec. 51009)
No impact on spending

This section extends the requirement that certain radiation therapy services remain at the current payment level through 2019, providing radiation oncologists more time to prepare for a possible alternative payment model.

TITLE XI: PROTECTING SENIORS’ ACCESS TO MEDICARE ACT

Repeal of the Independent Payment Advisory Board (Sec. 52001)
Spends $17 billion over 10 years

This section repeals the Independent Payment Advisory Board (IPAB) that is charged with making recommendations that reduce Medicare spending when per-capita growth exceeds an expenditure growth target. AHA has long advocated for the repeal of IPAB and was pleased at the inclusion of this provision.

TITLE XII: OFFSETS

Modifying Reductions in Medicaid DSH Allotments (Sec. 53101)
Saves $185 million over 10 years

The provision delays the scheduled Medicaid DSH allotment reductions for FYs 2018 and 2019. The DSH allotment reductions will be $4 billion for FY 2020 and $8 billion for FYs 2021 through 2025. AHA supported legislation to delay the Medicaid DSH cuts and has strongly advocated for this provision.

Third-party Liability in Medicaid and CHIP (Sec. 53102)
Saves $4 billion over 10 years

This provision makes several modifications in Medicaid third-party liability (TPL) rules that generally require that if a Medicaid beneficiary has another source of coverage, the insurer would be billed for the care before Medicaid. This provision expands the Medicaid TPL rules to CHIP, including repeal of a current rule exception for prenatal care. The provision also repeals a current law requirement that would have allowed states to recover medical expense claims from any portion of a Medicaid beneficiary settlement, including money set aside for a beneficiary’s future care or living expenses. In addition, it delays for two years a state option that allowed states to delay payment to providers for certain care for children, including Early and Periodic Screening, Diagnostic and Treatment services. GAO is instructed to examine the effects of TPL rule changes and report their findings to Congress.
**Treatment of Lottery Winnings and other Lump-sum Income for Purposes of income Eligibility under Medicaid**  
(Sec. 53103)  
Saves $475 million over 10 years

The provision modifies current rules to include lottery winnings and other lump-sum payments as income for purposes of determining Medicaid eligibility. An individual’s Medicaid ineligibility will be for a specified period depending on the size of the lump sum. States must notify individuals that lose Medicaid eligibility of the opportunity to enroll in a qualified health plan offered in the health insurance marketplace.

**Rebate Obligation with Respect to Line Extension Drugs** (Sec. 53104)  
Saves $5.6 billion over 10 years.

This provision fixes an error in the ACA impacting the rebate formula for “line extension drugs,” which are new versions of existing drugs that have only minor modifications. This provision establishes the rebate as the higher of either the rebate as calculated for the line extension drug or the rebate for the original drug.

**Medicaid Improvement Fund** (Sec. 53105)  
Saves $985 million over 10 years

This section rescinds $985 million from the Medicaid Improvement Fund.

**Physician Fee Schedule Update** (Sec. 53106)  
Saves $1.9 billion over 10 years  
The bill reduces the annual update to the conversion factor for the PFS for CY 2019 from 0.5 percent to 0.25 percent.

**Payment for Outpatient Physical Therapy Services and Outpatient Occupational Therapy Services Furnished by a Therapy Assistant** (Sec. 53107)  
Saves $1.2 billion over 10 years

This section reduces payments for outpatient physical or occupational therapy services provided on or after Jan. 1, 2022 in whole or in part by a therapy assistant to 85 percent of the otherwise applicable PFS amount. The provision also requires the HHS secretary to establish a modifier to identify services furnished by a therapy assistant, which must be included on relevant claims beginning Jan. 1, 2020. Finally, the provision requires the HHS secretary to implement it through notice-and-comment rulemaking.
Reduction for Non-emergency End-stage Renal Disease Ambulance Transport (Sec. 53108)
Scoring included with that of Section 50203

This section would reduce the amount that Medicare would otherwise pay for ambulance transports to and from a dialysis facility in non-emergency situations by an additional 13 percentage points (for a total reduction of 23 percent), beginning in FY 2019.

Hospital Transfer Policy for Early Discharges to Hospice Care (Sec. 53109)
Saves $4.9 billion over 10 years

This section establishes, beginning in FY 2019, a transfer payment policy for early hospital discharges to hospice care. Specifically, it expands the current Medicare inpatient PPS post-acute care transfer policy (in effect for early discharges to other hospitals and post-acute care facilities) to apply also to early discharges of Medicare beneficiaries to hospice care. This section also directs MedPAC to report on the effects of the change by March 15, 2021, with a preliminary evaluation provided by March 15, 2020. The AHA had urged Congress to reject this change, noting that it penalizes hospitals for respecting patients’ wishes and working to get them the appropriate care they want and need, when they need it.

Medicare Payment Update for HH Services (Sec. 53110)
Saves $3.5 billion over 10 years

This section sets the CY 2020 market-basket update for the HH PPS at 1.5 percent.

Medicare Payment Update for SNFs (Sec. 53111)
Saves $1.9 billion over 10 years

This section sets the FY 2019 market-basket update for the SNF PPS at 2.4 percent.

Preventing the Artificial Inflation of Star Ratings after the Consolidation of MA Plans Offered by the Same Organization (Sec. 53112)
Saves $520 million over 10 years

This section requires CMS to modify its rules for how it calculates MA star ratings for plans from the same MA organization that consolidate into a single plan. Specifically, CMS will use the enrollment-weighted average star ratings for the two plans for at least the first year post consolidation. The provision is intended to discourage the consolidation of MA plans from the same MA organization for the primary purpose of improving MA star ratings (and, therefore, payment).
Sunsetting Exclusion of Biosimilars from Medicare Part D Coverage Gap Discount Program (Sec. 53113)
Saves $10 billion over 10 years

Beginning with plan year 2019, biosimilars will now be included in the Part D coverage gap discount program. Currently, brand drug manufacturers are required to give price discounts when a beneficiary is in the “donut hole” – the point between when initial Part D coverage ends and before catastrophic coverage begins. Excluding biosimilars from this mandatory discount program has resulted in preferential treatment for other therapies, which could ultimately be more expensive. This provision is intended to make biosimilars more competitive with other therapies.

Adjustments to Medicare Part B and Part D Premium Subsidies for Higher Income Individuals (Sec. 53114)
Saves $1.6 billion over 10 years

Beginning in 2019, this section increases the Part B and Part D premiums paid by Medicare beneficiaries with modified adjusted gross incomes of at least $500,000 ($750,000 for a couple filing jointly). Specifically, these beneficiaries will pay 85 percent of the total premiums instead of 80 percent.

Medicare Improvement Fund (Sec. 53115)
Saves $300 million over 10 years

This section rescinds $220 million from the Medicare Improvement Fund.

Closing the Donut Hole for Seniors (Sec. 53116)
Scoring included with that of Section 53113

The ACA set forth a plan for closing the gap in Part D coverage referred to as the “donut hole.” This provision accelerates the timeframe for reducing the amount that Part D enrollees are required to pay in the donut hole by increasing the discount that drug manufacturers must provide. Starting in 2019, rather than 2020, enrollees will be responsible for 25 percent of the cost of brand name drugs in the donut hole, down from 35 percent today. Manufacturers will be required to provide a 70 percent discount in place of the current 50 percent. Health plans will be responsible for the remaining 5 percent.

Modernizing Child Support Enforcement Fees (Sec. 53117)
Saves $201 million over 10 years

The Deficit Reduction Act of 2005 required that individuals who have never received Temporary Assistance for Needy Families (TANF) benefits be charged an annual fee of $25 if the state collects more than $500 in child support on their behalf. This section changes the policy to instead require a fee of $35 if the state collects more than $550 in child support on behalf of an individual.
**Increasing Efficiency of Prison Data Reporting** (Sec. 53118)  
**Saves $82 million over 10 years**

Current law prohibits Supplemental Security Income (SSI) payments to individuals while they are in prison. To encourage correctional institutions to report this information, institutions that report information on an individual who, before confinement, received SSI can earn a payment of $400 if they report the individual’s information within 30 days, and $200 if this information is reported between 30 and 90 days after. This provision will require the institutions to report information within 15 days to receive a payment of $400.

**Prevention and Public Health Fund** (Sec. 53119)  
**Saves $998 million over 10 years**

This section reduces funding in the Prevention and Public Health Fund in order to generate $998 million in savings.

---

**DIVISION F: IMPROVEMENTS TO AGRICULTURAL PROGRAMS**

This division contains provisions related to agricultural subsidies, such as modifying the Margin Protection Program for Dairy Producers.

**DIVISION G: BUDGETARY EFFECTS**

This division waives, for virtually all of the bill’s provisions, the “pay-as-you-go” budget rule requiring that, relative to current law, any tax cuts or entitlement and other mandatory spending increases must be paid for by a tax increase or a cut in mandatory spending.

**FURTHER QUESTIONS**

If you have questions, please contact AHA Member Relations at 1-800-424-4301.