Friday, February 9, 2018

Congress Passes Short-term Spending Bill with Hospital Priorities

*Bill Includes DSH Relief, Extends Key Rural Programs*

Congress early this morning passed a short-term spending deal that includes a number of provisions of critical interest to hospitals and health systems. The Senate voted 71-28 to pass the bill, and the House passed it 240-186. President Trump has signed the bill, which ends a brief government shutdown that started at midnight when current funding expired. See Part I below for highlights of the health-care related provisions included in the bill.

In addition to funding the government through March 23, the deal raises the debt ceiling and sets spending levels for the next two years, raising defense and domestic spending by approximately $300 billion. It also includes about $90 billion in disaster relief funding for areas hard hit last year by hurricanes and wildfires (See Part II below for more).

In a statement, AHA President and CEO Rick Pollack said, “Today’s continuing resolution includes many important provisions that benefit the patients and communities America’s hospitals and health systems are privileged to serve each day."

Part I – Health Policy Changes and Extenders:

- **Children’s Health Insurance Program (CHIP) Funding** – The bill extends funding for CHIP for an additional four years on top of the six years included in the last continuing resolution through fiscal year (FY) 2027.

- **Medicaid Disproportionate Share Hospital (DSH) Payments** – As urged by AHA, the bill delays $5 billion in Medicaid DSH reductions scheduled for FYs 2018 and 2019. We are pleased the bill will allow this important source of funding to continue for hospitals as we continue to seek ways to reduce the number of uninsured.

- **Low-volume Adjustment (LVA) Program** – The bill extends for five years, through FY 2022, the enhanced LVA program, which expired Sept. 30, 2017. However, the bill changes the program so that, for FYs 2019 through 2022, the
add-on payment will be a sliding scale adjustment ranging from 25 percent for low-volume hospitals with total discharges of 500 or fewer, to no adjustment for hospitals with more than 3,800 total discharges. The bill also requires a study to examine payments made under the program.

- **Medicare-dependent Hospital (MDH) Program** – The bill extends for five years, through FY 2022, the MDH program, which expired Sept. 30, 2017, and requires a study to examine payments made under the program. AHA has long advocated for the extension of this vital program and will continue to advocate that it be made permanent.

- **Ambulance Add-on Payments** – As advocated by AHA, the bill extends the 2 percent urban and 3 percent rural ambulance add-on payment for five years through calendar year (CY) 2022. It also extends the “super rural” add-on through CY 2022.

- **Electronic Health Records (EHRs)** – The bill amends the Health Information Technology for Economic and Clinical Health (HITECH) Act to remove the mandate that meaningful use standards become more stringent over time. AHA advocated for this relief from Stage 3 provisions that are challenging to meet and require use of immature technology standards.

- **Opioid Funding** – The bill includes $6 billion in additional funding for combatting the opioid epidemic.

- **Medicaid Funding for Puerto Rico and the Virgin Islands** – The bill includes $4.9 billion in additional Medicaid funding for Puerto Rico and the U.S. Virgin Islands.

- **Independent Payment Advisory Board (IPAB)** – The bill repeals IPAB.

- **Telehealth** – The bill eliminates a geographic requirement under Medicare for the use of telehealth services for stroke patients, beginning in January 2019. 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.

- **Therapy Caps and Services** – The bill permanently repeals the Medicare payment caps for outpatient physical, speech language and occupational therapy services beginning Jan. 1, 2018 and lowers the threshold for targeted manual medical review to $3,000 from $3,700. The bill also reduces payments for physical or occupational outpatient therapy services provided on or after Jan. 1,
2022 to 85 percent of the otherwise applicable Physician Fee Schedule amount in certain circumstances.

- **Direct Supervision** – The bill extends the enforcement moratorium on “direct supervision” of outpatient therapeutic services for critical access hospitals and small, rural hospitals with 100 or fewer beds for CY 2017. The Centers for Medicare & Medicaid Services (CMS), in the CY 2018 outpatient prospective payment system (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. Further, the bill expands the type of personnel permitted to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs to include certain non-physician practitioners.

- **Home Health (HH)** – The bill includes several significant provisions related to home health. First, the bill restores a payment add-on for home health services in rural areas, after the prior, long-standing add-on expired on Jan. 1. This add-on would be in effect through Oct. 1, 2022 using a new methodology that aligns the amount of the add-on with a county’s level of population density. As an offset to this provision, the bill would reduce the FY 2019 HH PPS market basket to 1.5 percent. In addition, the bill would authorize an Office of Inspector General study by January 2023 that analyzes rural add-on payments by county and recommends whether the add-on should continue.

- **Skilled Nursing Facilities (SNFs)** – For FY 2019, the bill sets the market basket increase to 2.4 percent minus productivity.

- **Long-term Care Hospitals (LTCHs)** – The bill extends the current blended payment applied to LTCH site-neutral cases for an additional two years, which would now include cost-reporting periods beginning during FYs 2018 and 2019. To offset this provision, for FYs 2018 through 2026, the bill would reduce the market basket otherwise applied to LTCH site-neutral cases by 4.6 percent.

- **Veterans Health Administration (VA)** – The bill includes $4 billion to improve VA hospital and clinic facilities.

- **Geographic Practice Cost Index (GPCI)** – The bill extends the work GPCI floor, which increases payments for the work component of physician fees in areas where labor costs are lower than the national average, for two years, until CY 2020.

- **Special Needs Plans in Medicare Advantage (MA)** – The bill permanently extends special needs plans under the MA program.
• **National Quality Forum (NQF) Funding** – The bill extends funding for NQF’s measure endorsement activities by $7.5 million per year for two years, through FY 2019, and requires a report to Congress on its work. It also mandates a Government Accountability Office (GAO) study on how CMS uses NQF.

• **Physician Quality Payment Program** – The bill makes a number of technical changes to the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, including amending the legislation in several places so that Merit-based Incentive Payment System (MIPS) payment adjustments will apply only to covered professional services starting in 2020, rather than items and services. This means that Part B drug payments would no longer be factored into MIPS payment adjustments. In addition, the bill allows CMS three additional years (until 2024) to gradually increase the MIPS performance threshold score to the mean or median, and to raise the MIPS cost category to 30 percent of MIPS performance.

• **Accountable Care Organizations (ACOs)** – The bill provides two new resources for ACOs. First, the bill applies the Next Generation ACO telehealth waiver criterion to certain Medicare Shared Savings Program (MSSP) Track 2 and Track 3 ACOs, as well as certain other two-sided risk ACO participants, eliminating the geographic component of the originating site requirement under Medicare for the use of telehealth services, and allowing beneficiaries assigned to the approved MSSP and other ACOs to receive currently allowable telehealth services in the home. The bill also allows MSSP ACOs the choice to have their beneficiaries assigned prospectively at the beginning of the year, and allows certain two-sided risk ACOs to make incentive payments to assigned beneficiaries who receive qualifying primary care services.

• **Advanced Illness Management** – The bill orders the GAO to undertake a study within 18 months of enactment on the creation of a payment code for “longitudinal comprehensive care planning services” for Medicare beneficiaries diagnosed with a serious or life-threatening illness. The study will examine barriers faced by hospitals and other providers, as well as views on the need for the development of quality metrics with respect to these services.

• **Fraud and Abuse Provisions** – The bill codifies CMS’s recent changes to the Stark law, including clarifying 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 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.
• **Community Health Centers** – The bill extends funding for Community Health Centers for two years.

• **Medicare Hospice Payment Policy** – Beginning in FY 2019, the bill will reduce payments to hospitals when a hospital discharges a patient to hospice care early in their stay, similar to CMS’s post-acute care transfer policy. AHA had urged Congress to reject this change, noting that the policy change penalizes hospitals for respecting patients’ wishes and working to get them the appropriate care they want and need, when they need it.

• **Physician Fee Schedule Update** – The bill reduces the annual update to the conversion factor for the physician fee schedule for CY 2019 from 0.5 percent to 0.25 percent.

• **Reducing the Donut Hole for Seniors** – The bill reduces the so-called “Donut Hole,” a gap in Medicare drug coverage for seniors. It is offset by reduced reimbursements to drug manufacturers.

**Part II – Statutory Budget Cuts & the Debt Limit:**

• **Budget Caps** – The bill 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.

• **Emergency Spending** – The bill also includes $140 billion for defense and $20 billion for domestic emergency spending over two years.

• **Debt Ceiling** – The bill raises the debt ceiling until 2019.

These changes are not paid for with any additional cuts to payments to providers, which had been a primary concern for the field, as, in the past, budget cap and debt ceiling legislation has included significant cuts to payments to hospitals and health systems.