POLICY BRIEF

OVERVIEW OF THE *BIPARTISAN BUDGET ACT OF 2018*

On February 9, President Donald Trump signed into law the *Bipartisan Budget Act of 2018*, extending funding for the government through March 23, raising the federal debt limit until March 2019 and increasing funding for the military. Of interest to providers are the 378 pages of healthcare legislation, including "Medicare Extenders," the CHRONIC Care Act and adjustments to the Medicare Access and CHIP Reauthorization Act. A summary of key provisions that affect healthcare providers can be found below. The text of the healthcare legislation can be found here and a section by section summary can be found here.

Key Takeaways

- Changes to the Quality Payment Program ("QPP") are largely provider-friendly, addressing concerns surrounding cost scoring and shielding against short-term performance threshold increases. While efforts to reduce the burden of the Merit-Based Incentive ("MIPS") program are favored by many providers, Leading Health Systems that have made significant capital and resource investments may be disappointed with the slowdown. The provisions addressing the QPP delegate additional authority to the Centers for Medicare and Medicaid Services ("CMS") for near-term changes but fall short of structural reform.

- The changes to the ACO program, including formation of a beneficiary incentive payment program and giving providers choice in attribution methodology, are an indication that Congress is aware of attribution and patient retention issues that have hindered ACO's capacity to manage beneficiary populations and successfully lower costs.

- In sum, this legislation is a net positive for Leading Health Systems. The delay of Medicaid DSH cuts is a welcome relief in the face of financially damaging reductions to the 340B Drug Discount Program. The repeal of the Independent Payment Advisory Board has been long sought by providers who have expressed concern over unforeseen changes to Medicare. Finally, the bill provides new flexibilities in telehealth that allow for broader use for stroke and dialysis patients, as well as within certain ACOs.

- The passage of this legislation clears up pressing issues that have precluded Congress from focusing elsewhere. Members will now be able to shift to other issues, including a possible infrastructure package.

Quality Payment Program

There were several adjustments to the Quality Payment Program in the legislation and they are a net-positive for Leading Health Systems:

- *Easing the Burden of the Cost Category*: Part B drug costs have been eliminated from the Merit-Based Incentive Payment System ("MIPS") cost category score, and cost improvement will not be incorporated in the score for performance years 2018 through 2021. This provision allows CMS to set the weight for the overall cost category between 10 percent and 30 percent in years two through five of the program. CMS must include any measures under development, a development timeline, and the percent of Part A and B expenditures covered by the proposed measures.

    - *Key Takeaway*: While cost scoring will still be a driver of performance, CMS will likely be more judicious in increasing the weight of the cost category over the next three years. 2018 cost performance data will likely serve as a benchmark and determine how much cost weighting is increased.

- *Reducing the Performance Threshold*: The performance threshold was slated to be set at the mean or median of the performance distribution in 2019; however, this provision allows for the performance threshold to be set by CMS and gradually scaled up in years three through five.

    - *Key Takeaway*: While a slower scale-up reduces urgency to report, it also means the program will have limited upside for high performers.

- *Strengthening the Pipeline of New Alternative Payment Models*: This provision allows Physician-Focused Technical Advisory Committee ("PTAC") to provide additional feedback to developers of new payment models. PTAC can also provide comments along with their model recommendations to the Secretary of Health and Human Services.

    - *Key Takeaway*: The introduction of new APMs has been slowed with the change in administration and subsequent change in leadership within HHS. With the new appointment of the HHS Secretary and the additional authority granted to PTAC, both the rate and quality of new APM proposals stand to improve.

Accountable Care and Managed Care (Medicare Advantage)

The legislation includes the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which was passed by the Senate in 2017, but never voted on in the House. Key provisions to Leading Health Systems include:

- *Providing Flexibility to Accountable Care Organization ("ACO") Beneficiaries*: This provision will allow ACOs in the Medicare Shared Savings Program ("MSSP") to benefit from prospective beneficiary assignment at the beginning of a performance year. It will also allow individual beneficiaries to opt into the MSSP ACO in which their main primary care provider participates.

    - *Key Takeaway*: Retrospective assignment has been a continued area of frustration for providers in the ACO program. Prospective assignment in combination with allowing beneficiaries to choose to be affiliated with an MSSP ACO should improve provider's capacity to track and manage the care of ACO beneficiaries.

- *Eliminating Barriers to Care Coordination Under Accountable Care Organizations*: This provision will allow practices in the MSSP Track 2 and Track 3 ACOs to provide incentive payments to beneficiaries who receive qualifying primary care services. The payments would be up to $20 per qualifying service, though the incentive payments would not be tied to any additional reimbursements.

    - *Key Takeaway*: This provision allows providers to enhance their capability to engage beneficiaries, improving attribution, retention, and patient outcomes.

- *Expanding Access to Home Dialysis*: Beginning January 1, 2019, beneficiaries on home dialysis will be eligible to use telehealth for required monthly clinical assessments. Medicare will not provide a separate payment for the originating site fee if the service is furnished in the home. A beneficiary will be required to receive their first three clinical assessments and at least one out of every three monthly assessments thereafter through an in-person encounter.

- *Increasing Convenience for Medicare Advantage Enrollees Through Telehealth*: Under current law the Medicare program recognizes and pays for only certain Medicare Part B telehealth services. This provision will allow Medicare Advantage (MA) plans to include additional telehealth benefits in their plan bids, as opposed to financing additional telehealth services through rebate dollars, beginning in 2020. The Secretary will solicit comments on what types of services should be permitted through MA plans.

- *Key Takeaway*: Members of both sides of the aisle have expressed interest in advancing telehealth policy and these provisions—many of which were contained in the CHRONIC Care Act—have received strong support. Though current expansions apply to two-sided risk environments, Congress seems to have strong interest in continuing to expand telehealth policy.

Additional Provisions

Additional provisions contained in the legislation that are impactful to Leading Health Systems include:

- *Modifying Reductions in Medicaid Disproportionate Share Hospital (DSH) Allotments*: Reductions to the DSH program, which provides additional funding for hospitals that serve a large number of Medicaid and low-income patients, went into effect in January. This provision delays DSH reductions to FY 2020.

    - *Key Takeaway*: This provision is a welcome relief to DSH recipients, the majority of whom are enrolled in the 340B Drug Discount Program and have been severely impacted by reduced funding. However, the DSH reductions are temporary and recipients will again need to stave off $44 billion in cuts scheduled to commence in FY 2020.

- *Repeal of the Independent Payment Advisory Board ("IPAB"):* This provision eliminates IPAB, which was created (but never enacted) by the Affordable Care Act to reduce Medicare spending.

    - *Key Takeaway*: While this was a victory for providers, many of whom have sought to repeal the 15-person board since its creation, it was a bigger win for Congress, which did not want to relinquish control of the Medicare program.

- *Hospital Transfer Policy For Early Discharges To Hospice Care*: This provision applies the current Medicare hospital transfer payment policy (in effect for early discharges to other hospitals and to post-acute care facilities) to hospitals that discharge Medicare beneficiaries early to hospice care – hospitals will now be paid a per-diem rate instead of the MS-DRG amount if the patient is transferred early, which is defined as a length of stay at least one day less than the mean length of stay for the MS-DRG.

    - *Key Takeaway*: This provision will adversely impact providers, since there will be a reduction in payment rate in cases of early transfers to hospice facilities.

- *Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals*: Currently, hospitals with 1,600 or fewer annual Medicare discharges receive an additional payment on a sliding scale up to 25 percent. The law extends this funding through the end of FY 2022, but changes the methodology from Medicare discharges to total discharges. Beginning in FY 2019, the payment adjustment will apply on a sliding scale up to 25 percent to hospitals with fewer than 3,800 total discharges.

    - *Key Takeaway*: This provision was designed for low-volume hospitals. The Medicare Payment Advisory Commission ("MedPAC") has advised Congress that hospitals with low Medicare volumes but high commercial volumes are disproportionately benefitting from the current statute.

- *Extension of the Children's Health Insurance Program ("CHIP"):* Following the six-year extension of CHIP, passed in the previous CR, the legislation extends funding for the program another four years, through FY 2027.

    - *Key Takeaway*: The CHIP program became a political football for the past few months. This extension ensures the program ensures continuity for the program for a decade.

- *Extension for Community Health Centers*: This provision will provide $8b in funding for the nation's 1,300+ community health centers over the next two years.

    - *Key Takeaway*: Beyond providing funding, the intent of this provision seems to be to more closely align community health centers with providers.

- *Closing the Donut Hole for Seniors*: The Affordable Care Act contained a provision to end the "donut hole," which leaves seniors and disabled beneficiaries vulnerable to large portions of their drug costs, by 2020. This provision accelerates the end of the donut hole to 2019 and Part D beneficiaries will be responsible for, at most, 25 percent of their drug costs. Additionally, drug manufacturers must increase their discount of the cost of prescriptions for Part D recipients from 50 percent to 70 percent, beginning in 2019.

    - *Key Takeaway*: This is a positive for seniors who have been vulnerable to high cost sharing for prescription drugs. Pharmaceutical Research and Manufacturers of America ("PhRMA"), the trade association for branded drug companies, immediately expressed concern over the discount increase, but the impact of this provision is less damaging to drug manufacturers than other policies being evaluated to address drug prices (e.g., the CREATES Act, which was not included in the legislation).