Wynne Health Group

Issue Brief

February 9, 2018

WHAT'S IN THE BIPARTISAN BUDGET DEAL: AN EXAMINATION OF HEALTH AND HUMAN SERVICES PROVISIONS

INTRODUCTION

This week, House and Senate leaders reached a bipartisan budget deal to lift spending caps over two years – fiscal years (FYs) 2018 and 2019 – by $315 billion.[1] The measure also increases the Federal debt limit through 2018. The Senate and House took early-morning votes to pass the bill after a brief intervening shutdown, with Sen. Rand Paul (R-KY) having objected to moving to the bill sooner. President Trump signed the legislation Friday morning. The agreement would eliminate the non-defense and defense discretionary sequester in both years and provide equal increase for defense and nondefense spending. Non-defense spending would increase by $131 billion.

The Senate's legislation largely includes the House-passed Continuing Resolution (CR) funding the government through March 23, including two years of community health center funding, a two-year delay of Medicaid disproportionate share hospital (DSH) cuts, and a permanent fix for Medicare therapy caps, among other provisions of the House's bill released earlier this week. The Senate package, while including those major House-passed items, adds numerous other healthcare provisions such as repeal of the Affordable Care Act (ACA) Independent Payment Advisory Board (IPAB) and four more years of Children's Health Insurance Program (CHIP) funding.

Unlike the House-passed CR, the Senate bill also halts Defense funding on March 23, rather than extending through the end of the fiscal year. With the new budget caps in place, the stop-gap measure would provide Congress six weeks to finalize work on an omnibus FY 2018 appropriations package that will likely hinge on bipartisan agreement on immigration policies for Dreamers.

Significant offsets are included, with the Senate raising drug manufacturers' brand-name discounts in the donut hole to 70 percent in 2019. Additional offsets address cross-walking of Medicare Advantage Star ratings, Medicaid third-party liability, rebate obligations for line-extension drugs, and more.

Following is a summary of the Health and Human Services provisions within Division E of bill, known as the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act:

[1] http://docs.house.gov/billsthisweek/20180205/BILLS-%20115HR1892SAmdt2.pdf

TITLE I – CHILDREN'S HEALTH INSURANCE PROGRAM

- **CHIP funding extension through FY 2027 (Sec. 50101) –** The budget deal extends CHIP funding for an additional four years. Combined with a six-year extension enacted through the most recent CR, this means the CHIP program will be extended for a full decade *(CBO: -$260m/10y)*.

TITLE II – MEDICARE EXTENDERS

Medicare Part A

- **Low-volume hospitals (Sec. 50204) –** Low-volume hospitals receive higher payments due to relatively high costs associated with low discharge rates and distance from other hospitals. They will continue to receive higher payments through Oct. 1, 2022, a five-year extension. The provision also modifies low-volume payment adjustments, basing them on total discharges, with a transition period *(CBO: $1.82b10y)*.

- **Medicare-dependent hospital (MDH) program (Sec. 50205) –** MDHs are designated as such based on small size, rural geography, and high proportion of elderly patients; they receive higher payments from Medicare, and will now continue to do so through Oct. 1, 2022, a five-year extension *(CBO: $890m/10y)*.

Medicare Part B

- **Extension of work Geographic Practice Cost Indices (GPCI) floor (Sec. 50201) –** GPCI adjusts physician reimbursements based on geography, but has not recently docked physicians in areas where the cost of physician work is lower than the national average. That will continue to be the case until Jan. 1, 2020, in a two-year extension *(CBO: $955m/10y)*.

- **Repeal of Medicare payment cap for therapy services; replacement with limitation to ensure appropriate therapy (Sec. 50202) –** Medicare reimbursements for outpatient therapy are technically capped, although that cap has never been in effect. That cap is now permanently repealed effective Jan. 1, 2018 *(CBO: $6.47b/10y)*.

- **Ground ambulance services (Sec. 50203) –** Ambulatory care reimbursements include additional payments depending on geography, the lowest increases for urban areas and the highest for "super rural." This section requires annual cost reporting and extends ambulatory add-on payments through Dec. 31, 2022, a five-year extension *(CBO: -$155m/10y)*.

Home Health Policies

- **Extension of home health rural add-on (Sec. 50208) –** Home health care providers in rural areas receive higher payments from Medicare and will continue to do so under a new methodology for especially-low-density areas until Oct. 1, 2022, a five-year extension *(CBO: $375m/10y)*.

Extensions of Other Funding

- **Extension of funding for quality measure endorsement, input, and selection; reporting requirements (Sec. 50206) –** The contract between the Department of Health and Human Services and a consensus-based entity charged with improving and measuring performance will continue through Sept. 30, 2019, a two-year extension with $7.5 million appropriated for each fiscal year *(CBO: $15m/10y)*.

- **Extension of certain MIPPA (Medicare Improvements for Patients and Providers Act of 2008) funding provisions (Sec. 50207) –** State health insurance assistance program reporting requirements and outreach, counseling, and information assistance to Medicare beneficiaries will now continue through Sept. 30, 2019, a two-year extension *(CBO: $75m/10y)*.

TITLE III – CREATING HIGH-QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE

- **Extending the Independence at Home Demonstration Program (Sec. 50301) –** The Independence at Home (IAH) Demonstration was authorized by the ACA to test home-based interventions for beneficiaries with multiple chronic illnesses. This section would extend the IAH Demonstration by two years, expand it from 10,000 to 15,000 beneficiaries, and give participating practices three years generate savings against their spending targets *(CBO: $23m/10y)*.

- **Expanding access to home dialysis therapy via telehealth (Sec. 50302) –** Beginning Jan. 1, 2019, expands the ability of beneficiaries on home dialysis to receive required monthly clinical assessments to monitor their condition using telehealth. Expands originating sites to include the beneficiary's home and freestanding dialysis facilities, and eliminates geographic restrictions *(CBO: budget neutral)*.

- **Permanent authorization Medicare Advantage special needs plans (Sec. 50311) –** Permanently authorizes the I-SNP, D-SNP and C-SNP if certain requirements are met. Establishes requirements for federal-state coordination with states, specific requirements by plan type, eligibility requirements, among others such as a Secretarial option to implement quality star ratings for SNPs at the plan level *(CBO: $125m/10y)*.

- **Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees (Sec. 50321) –** The CMMI Value-Based Insurance Design (VBID) Model helps MA plans to meet the needs of chronically ill enrollees by allowing for additional flexibility in benefit design. This provision would expand the model to allow an MA plan in any state to participate in the model by 2020 *(CBO: $45m/10y)*.

- **Expanding supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees (Sec. 50322) –** Plans must offer required Medicare benefits and may offer additional or supplemental benefits. Supplemental benefits must be offered to all plan enrollees. This section

would allow an MA plan to offer a wider array of supplemental benefits and to target them specifically to chronically ill enrollees beginning in 2020. *(CBO: budget neutral)*.

- **Increasing convenience for Medicare Advantage enrollees through telehealth (Sec. 50323) –** This provision would allow an MA plan to offer additional telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B beginning in 2020. Focus would be placed on non-face-to-face communication such as remote patient monitoring, secure messaging, and store and forward technologies *(CBO: -$80m/10y)*.

- **Providing accountable care organizations the ability to expand the use of telehealth (Sec. 50324) -** This section would apply the Next Generation ACO telehealth waiver criterion to the Medicare Shared Savings Program (MSSP) Track II, MSSP Track III, and two-sided risk ACO models with prospective assignment that are tested or expanded through CMMI. The telehealth waiver would relax originating site requirements for these models *(CBO: $50m/10y)*.

- **Expanding the use of telehealth for individuals with stroke (Sec. 50325) –** This provision would eliminate the geographic restrictions for telestroke as to permit payment to physicians furnishing the telehealth consultation service in all areas of the country *(CBO: $230m/10y)*.

- **Providing flexibility for beneficiaries to be part of an accountable care organization (Section 50331) –** Beneficiaries currently do not have the option of choosing to participate directly in an ACO. This section would amend the law to give ACOs in the MSSP the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. Additionally, this provision would give a beneficiary the option to voluntarily align to the MSSP ACO in which the beneficiary's main primary care provider is participating *(CBO: $50m/10y)*.

- **Eliminating barriers to care coordination under accountable care organizations (Sec. 50341) –** This section would establish the ACO Beneficiary Incentive Program (BIP). The ACO BIP would create a process that allows ACOs to make incentive payments to all assigned beneficiaries that receive qualifying primary care services. ACOs would be allowed to offer a flat payment, of up to $20 per qualifying service, directly to the beneficiary. *(CBO: -$54m/10y)*.

- **GAO study and report on longitudinal comprehensive care planning services under Medicare Part B (Sec. 50342) –** This section would direct Government Accountability Office (GAO) to submit a report to Congress within 18 months to inform the development of a payment code describing the formulation of a comprehensive plan of longitudinal care for a Medicare beneficiary diagnosed with a serious or life-threatening illness *(CBO: budget neutral)*.

- **GAO study and report on improving medication synchronization (Sec. 50351) –** This section would direct GAO to submit a report to Congress within 18 months that would provide information on the prevalence and effectiveness of Medicare and other payer medication synchronization programs *(CBO: budget neutral)*.

- **GAO study and report on impact of obesity drugs on patient health and spending (Sec. 50352)** - 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 *(CBO: budget neutral)*.

- **Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes (Sec. 50354)** – Certain Medicare beneficiaries who meet criteria described in statute are eligible to enroll in medication therapy management (MTM) programs offered by Part D plans (PDPs). MTM's purpose is to coordinate prescription drugs for high-cost beneficiaries. PDPs however do not have access FFS utilization data that may aid the PDP in coordination efforts *(CBO: budget neutral)*.

TITLE IV – PART B IMPROVEMENT ACT AND OTHER PART B ENHANCEMENTS

Title IV includes several provisions derived from House-backed bipartisan legislation, the Medicare Part B Improvement Act of 2017 (H.R. 3178), which passed the House last July.[2] It also includes components of various other legislation advanced by key members of the House Ways and Means (W&M) Committee and/or House Energy and Commerce (E&C) Committee.[3] Among the provisions:

- **Temporary transitional payment for home infusion therapy services (Sec. 50401) –** The 21st Century Cures Act[4], passed in December 2016, changed the way Medicare reimburses for the acquisition of home infusion drugs, beginning this year; and, beginning in 2021, also created a new benefit to reimburse for the necessary education services associated with educating Medicare beneficiaries on home infusion services. The provision aims to address the four-year implementation "gap" by creating a temporary transition payment, beginning in 2019, for home infusion service and education[5] *(CBO: -$910m/10y)*.

- **Orthotist's and prosthetist's clinical notes as part of the patient's medical record (Sec. 50402)** – The provision stipulates that the documentation created by an orthotist or prosthetist be considered as part of a Medicare beneficiary's medical record for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics *(CBO: budget neutral)*.

- **Independent accreditation for dialysis facilities and assurance of high quality surveys (Sec. 50403) –** The provision allows dialysis facilities to be accredited by an outside Medicare-approved accreditation body, in addition to delineating a timeframe for the initial survey of new dialysis facilities *(CBO: budget neutral)*.

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[2] https://www.congress.gov/bill/115th-congress/house-bill/3178?q=%7B%22search%22%3A%5B%22H.R.+3178%22%5D%7D&r=1

[3] https://energycommerce.house.gov/news/press-release/house-passes-cr-funding-community-health-centers-health-priorities/

[4] See sec. 5012 of the Cures Act: https://www.congress.gov/bill/114th-congress/house-bill/34/

[5] https://energycommerce.house.gov/news/press-release/house-passes-critical-bill-aligning-policies-ensure-access-home-infusion/

- **Modernizing the application of the Medicare "Stark Rule" (Sec. 50404) –** Codifies recent CMS Stark law regulations[6] pertaining to signature requirements and lease arrangements *(CBO: budget neutral)*.

- **Making permanent the removal of the rental cap for Medicare DME with respect to speech generating devices (Sec. 50411) –** Consistent with legislation introduced in the House and Senate, the Steve Gleason Enduring Voices Act (H.R. 2465[7] and S. 1132[8]), the provision makes permanent the removal of the Medicare Durable Medical Equipment (DME) rental cap for speech-generating devices. Prior legislation passed in 2015 removed speech-generating devices from the capped rental categorization but only for a three-year period, sunsetting in 2018[9] *(CBO: +$12m/10y)*.

- **Increased civil and criminal penalties and increased sentences for Federal health care program fraud and abuse (Sec. 50412) –** The provision increases Medicare civil and criminal penalties, as well as sentences for felonies, involving federal health care fraud and abuse. The changes apply to acts committed following enactment of the legislation *(CBO: budget neutral)*.

- **Reducing the volume of future EHR-related significant hardship requests (Sec. 50413) –** The provision aims to reduce the volume of future electronic health record (EHR)-related significant hardship requests and is predicated on bipartisan House legislation (H.R. 3120) reported out of the House E&C Committee last December[10] *(CBO: budget neutral)*.

- **Strengthening rules in case of competition for diabetic testing strips (Sec. 50414) –** The provision aims to enhance consumer protections under the competitive bidding program (CBP) for Diabetes Test Strips (DTS). Specifically, as the champions of related legislation[11] underscore, the provision "strengthen[s] enforcement of current law requirements that suppliers in the CBP must include at least 50 percent of the types of test systems that were on the market before the CBP's implementation…"[12] The measure also includes consumer protections that "prohibit suppliers from encouraging beneficiaries to switch from one testing system to another," etc.[13] *(CBO: budget neutral)*.

TITLE V– OTHER HEALTH EXTENDERS

Titles V provides two years of funding for three public health programs: Family-to-Family Health Information Centers, the Personal Responsibility Education Program, and the Sexual Risk Avoidance

[6] https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf
[7] https://www.congress.gov/bill/115th-congress/house-bill/2465
[8] https://www.congress.gov/bill/115th-congress/senate-bill/1132/related-bills
[9] https://mcmorris.house.gov/steve-gleason-act-passes-house-heads-to-presidents-desk/
[10] https://www.congress.gov/bill/115th-congress/house-bill/3120/all-actions
[11] https://www.congress.gov/bill/115th-congress/house-bill/3271 and https://www.congress.gov/bill/115th-congress/senate-bill/1914
[12] https://susanwbrooks.house.gov/media-center/press-releases/bipartisan-bill-protects-diabetic-medicare-beneficiaries-access-to
[13] Ibid.

Education Program. The funding allocated for these programs, CBO projected costs, and general impacts are outlined in the table below.

Table A: ***Public Health Extensions***

Program	Funding (FY 2018 & 2019)	CBO Estimate[14] (over 10 years)	Impact
Family-to-Family Health Information Centers	**$6 million per year**	**$12 million**	Family-to-Family Information Centers help children with special health care needs and the professionals who serve them.[15] The bill providers for the development of new centers in all territories and at least one center to serve Indian tribes.
Personal Responsibility Education Program	**$75 million per year**	**$149 million**	Provides for "competitive prep grants" and expands the focus to include help for victims of human trafficking. The program focuses on ending youth homelessness, adolescent pregnancy, and domestic violence.[16]
Sexual Risk Avoidance Education Program	**$75 million per year**	**$139 million**	The program's mission is to end youth homelessness, adolescent pregnancy, and domestic violence.[17] The bill includes requirements regarding content and specifies that it must be medically accurate. It requires factual information about contraceptives but prohibits demonstration. National evaluation is required.

TITLE VI – CHILD AND FAMILY SERVICES AND SUPPORTS EXTENDERS

- **MIECHV (Sec. 50601)** – The legislation extends the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program at the current level of $400 million per year through FY 2022. Additional provisions require ongoing analysis, demonstration of efficacy, and needs assessments, and allow for up to 25 percent of funding to be used for "pay for outcome initiatives" in which grants, contracts, or other agreements are awarded by public entities to generate specified social benefits without requiring a prescribed approach *(CBO: $1.98b/10y)*.

- **Health workforce demonstration (Sec. 50611)** – The bill will also extend through FY 2019 the Health Workforce Demonstration Project at current funding levels. The program provides funding to help low-income individuals obtain education and training in high-demand, well-paid, health care jobs *(CBO: $164m/10y)*.

TITLE VII – FAMILY FIRST PREVENTION SERVICES ACT

The legislation incorporates provisions of a bill that would allow states the option to direct federal child welfare (Foster Care and Adoptions Assistance) funds available under Titles IV-B and IV-E of the Social Security Act to provide services that enable children to stay at home or with kin, rather than being placed

[14] Congressional Budget Office. February 8, 2018. Details here.
[15] Family to Family Health Centers. Additional information available here and here.
[16] U.S. Department of Health and Human Services, Family and Youth Services Bureau. Details available here.
[17] U.S. Department of Health and Human Services, Family and Youth Services Bureau. Details available here.

in foster care. Such services include mental health and substance abuse prevention and treatment services, in-home parenting skill and education programs, and counseling.

The bill includes a maintenance of effort (MOE) provision that allows smaller states to choose from three possible base years; would limit federal spending on the use of congregate or "group home" care settings for foster youth; offers funding for evidence-based "kinship navigator" programs that link relative caregivers to services and supports so that they may maintain foster eligibility; and extends funding for reunification services for children returning from foster care.

Additionally, the bill extends several established programs including the Stephanie Tubbs Jones Child Welfare Services Program, the Promoting Safe and Stable Families Program, and the John H. Chafee Foster Care Independence Program, and creates a new program to assist states in staffing qualified personnel.

TITLE IX – PUBLIC HEALTH PROGRAMS

Titles IX of the bill allocates two years of funding for public health programs including Community Health Centers, the National Health Service Corps, Graduate Medical Education, and the Special Diabetes Program. The funding levels, CBO estimates, and high-level impact are outlined in Table B below.

Table B: ***Public Health Extensions***

Program	Funding (FY 2018 & 2019)	CBO Estimate[18] (over 10 years)	Impact
Community Health Center Fund	**$3.8 billion for FY 2018; $4.0 billion for FY 2019**	**$8.042 billion** (Estimate combines cost of CHCs, NHSC, and GME)	Authorizes the Secretary to award supplemental grant funds to improve quality of care potentially impacting delivery of care for persons with multiple chronic conditions, workforce configuration, reducing the cost of care, enhancing care coordination, expanding the use of telehealth and technology-enabled collaborative learning, mental health integration, emerging public health issues, and/or substance use disorders.
National Health Service Corps	**$310 million per year**		National Health Service Corps expands access to primary care in hard to reach areas.[19]
Teaching Health Center Graduate Medical Education Program	**$126.5 million per year**		Priority is given to teaching health centers in heath provider shortage areas with specific designation, are rural, or serve a medically underserved community.
Special Diabetes Program for Type 1 Diabetes	**$150 million per year**	**$488 million**	The program helps treat and prevent Type 1 diabetes among Indians (Native Americans).

[18] Congressional Budget Office. February 8, 2018. Details here.
[19] National Health Service Corps, Health Resources and Services Administration. Additional details here.

TITLE XI – IPAB REPEAL

The Senate language would repeal the Independent Payment Advisory Board (IPAB). CBO estimates the provision would increase the deficit by $17.49 billion over 10 years. Authorized by the ACA, IPAB was intended to be a board of independent experts directed to recommend Medicare spending reductions to Congress and the Administration if the per capita growth in Medicare spending ever exceeds a specified level. The House passed IPAB repeal in late 2017, although such legislation had languished in the Senate.

TITLE X – MISC. HEALTH PROVISIONS

- **Home health payment reform –** HHS is now required to reform the current home health payment system beginning in 2020, with 30-day episodes and case-mix methodology changes *(CBO: budget neutral)*.

- **Information to satisfy documentation of Medicare eligibility for home health services –** The Secretary is now allowed to use medical records of both home health providers and physicians to determine a patient's eligibility for home health *(CBO: $20m/10y)*.

- **Technical amendments to Public Law 114-10 –** Certain technical corrections are made to MACRA, including by extending by three years the ability of the Centers for Medicare and Medicaid Services (CMS) to apply the 30 percent resource use performance score and its transition to its stipulated performance threshold (*CBO: budget neutral*).

- **Expanded access to Medicare intensive cardiac rehabilitation programs –** Qualification guidelines for becoming a provider of intensive cardiac rehabilitation are updated (not scored separately).

- **Extension of blended site-neutral rate for certain LTCH discharges –** Under this section, the 50/50 blend is extended through FY 2019, offset by a 4.6 percent cut in the LTCH per diem rate (*CBO: -$45m/10y*).

- **Recognition of physician assistants as attending physicians for hospice –** PAs could serve as attending physicians for purposes of billing and establishing the plan of care, although they could not certify or recertify patients for hospice care. Effective CY 2019 (*CBO: $260m/10y*).

- **Extension of enforcement instruction on Medicare supervision requirements for outpatient therapeutic services in critical access and small rural hospitals –** This section disallows Medicare from enforcing "unreasonable and inflexible" direct supervision rules for outpatient therapy at critical access hospitals through CY 2017 (*CBO: budget neutral*).

- **NP, PA, clinical nurse specialist supervision of cardiac, intensive cardiac and pulmonary rehab –** Specified practitioners would be able to supervise these programs as of Jan. 1, 2024 (*CBO: $290m/10y*).

- **Transitional payment rules for certain radiation therapy services –** With alternative payment models potentially on the horizon, certain services would remain at the current payment level under the Medicare Physician Fee Schedule through CY 2019 in an effort to provide radiation oncologists lead-time to prepare (*CBO: budget neutral*).

TITLE IX – OFFSETS

The budget deal text adds more offsets beyond those delineated in the House-passed CR and revises several others. Below is a summary of the offsets included in the Senate text:

- **Medicaid DSH cut delay (Section 53101) –** Statutory cuts to Medicaid DSH hospitals are delayed by two years so that instead of taking effect in FY 2018, they take effect in FY 2020. The FY 2020 cut would be $4 billion. FY 2021-2025 cuts would be $8 billion per year *(CBO: -$185m/10y)*.

- **Medicaid and CHIP third party liability (Section 53102) –** The section repeals a BBA provision that would have enabled states to recover medical expenses from Medicaid beneficiary settlements. The provision also addresses provisions on payer of last resort and removes the requirement that states pay providers of prenatal care first prior to seeking third-party payment. A statutory provision giving states the option to delay reimbursement for certain pediatric care (including EPSDT) for up to 90 days during efforts to obtain third-party payment is delayed for two years until Oct. 1, 2019. The provision also applies third-party liability requirements to CHIP *(CBO: -$4.0b/10y)*.

- **Treatment of lottery winnings and lump sums for Medicaid eligibility (Section 53103) –** The bill requires a state Medicaid program to count lottery winnings of $80,000 or higher in more than just the month such payments are received for purposes of determining individual's eligibility for a state Medicaid program under Modified Adjusted Gross Income (MAGI) rules *(CBO: -$475m/10y)*.

- **Rebate obligation for line extension drugs (Section 53104) –** Under this provision, the line-extension rebate is the greater of either the base rebate plus the additional rebate, or the base rebate plus the line extension rebate. Prior law allowed for the greater of the additional rebate or the line extension rebate. The new policy is effective for rebate periods beginning on or after Oct. 1, 2018 *(CBO: -$5.65b/10y)*.

- **Medicaid Improvement Fund (Section 53105) –** $985 million is rescinded from the Medicaid Improvement Fund *(CBO: -$985m/10y)*.

- **Physician Fee Schedule update (Section 53106) –** The provision reduces a 0.5 percent statutory physician fee schedule update to 0.25 percent for 2019 *(CBO: -$1.85b/10y)*.

- **Payment for outpatient physical therapy and occupational therapy furnished by a therapy assistant (Section 53107) –** Under the provision, the rate for Part B therapy services furnished all

or in part by a physical and occupational therapy assistant would be 85-percent of the rate that would have otherwise been paid for a physician. This aligns with Medicare's payment practices for ancillary services providers *(CBO: -$1.2b/10y)*.

- **Reduction for non-emergency ESRD ambulance transfers (Section 53108) –** The provision would increase the current law payment reduction for non-emergency dialysis ambulance transports to 23-percent beginning Oct. 1, 2018 *(CBO: not scored separately)*.

- **Hospital transfer policy for early discharges to hospice (Section 53109) –** Under this section, hospice is added as a setting of care to CMS' existing post-acute care transfer policy. The policy only applies in those cases where the patient falls into one of the top 10 reimbursed hospital stays. The policy would begin on Oct. 1, 2018, which is sooner than the Oct. 1, 2023, originally envisioned by the House legislation *(CBO: -$4.9b/10y)*.

- **Medicare payment update for home health (Section 53110) –** The provision specifies a 1.5 percent increase for home health providers in 2020 *(CBO: -$3.5b/10y)*.

- **Medicare payment update for skilled nursing (Section 53111) –** SNFs will receive a 2.4 percent market basket increase under the SNF PPS in 2019 *(CBO: -$1.925b/10y)*.

- **Preventing artificial inflation of Star ratings after MA contract consolidation (i.e., Cross-Walking) (Section 53112) –** Effective Jan. 1, 2019, consolidating contracts would "reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts" as HHS determines appropriate *(CBO: -$520m/10y)*.

- **Sunset of exclusion of biosimilars from Medicare Part D coverage gap discount (Section 53113) –** Beginning in plan year 2019, biosimilars would be included in receiving manufacturer discounts in the donut hole *(CBO: -$10.1b/10y, including earlier closing of donut hole provision)*.

- **Adjustments to Medicare Parts B and D premium subsidies for high income individuals (Section 53114) –** Higher income beneficiaries would pay a higher percentage of Part B and Part B premiums beginning in 2019, with those earning more than $500,000 paying 85 percent, up from 80 percent. Indexing of the thresholds would begin in 2028 *(CBO: -$1.6b/10y)*.

- **Medicare Improvement Fund (Section 53115) –** $220 million in funding is rescinded (CBO: -$300m/10y).

- **Closing the donut hole in 2019 through higher manufacturer discounts (Section 53116) –** The text accelerates the closure of the Part D donut hole to 2019 (instead of 2020 in current law) and places the cost on manufacturers. It raises manufacturer discounts to 70 percent starting in 2019, with plan sponsors paying five percent. An earlier draft would have required manufacturers to pay 75 percent discounts.

Under current law, manufacturer discounts would be 50 percent in 2019 with the beneficiary paying 30 percent and the Part D plan paying 20 percent. No changes are made with respect to the ongoing counting of discounts toward TrOOP (*CBO: -$10.1b/10y, including adding biosimilars to discount program).*

- **Child Support enforcement fees (Section 53117) –** The annual fee is increased to $35 if a state collects more than $550 in child support for an individual *(CBO: -$201m/10y)*.

- **Increasing efficiency of prison data reporting (Section 53118) –** The provision provides for an accelerated 15-day timeline for prisons' reporting of information on individuals' SSI in order to qualify for a $400 payment that previously was available for reporting within 30 days *(CBO: -$82m/10y)*.

- **Prevention and Public Health Fund (Section 53119) –** Mandatory funding is cut by $1.35 billion *(CBO: -$998m/10y)*.

CONCLUSION

We hope this is a helpful overview of the bipartisan budget deal's Health and Human Services titles and its significant implications for stakeholders across the healthcare continuum. We would be happy to schedule a conference call to discuss specific implications of the legislation for your organization, as well as provide further details on any specific provisions of interest.