PUBLICATION

Medicare Extenders Included in House-Passed Continuing Resolution

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On February 6, 2018, the House voted 242-182 to pass a Continuing Resolution (CR) to extend government funding until March 23, 2018 (H.R. Res 128). The CR includes provisions to extend funding for a number of Medicare extenders and public health programs, including community health centers. The legislation also incorporates provisions from several Medicare bills that have previously passed out of the House or Senate, including the CHRONIC Care Act and the Medicare Part B Improvement Act. Finally, the legislation would eliminate the Medicaid Disproportionate Share Hospital (DSH) reductions scheduled for Fiscal Year (FY) 2018 and 2019 under current law, while adding further reductions in later years. The package is fully paid for with several health-related fiscal offsets.

In the final vote in the House, 228 Republicans and 17 Democrats voted in favor, while eight Republicans and 174 Democrats voted in opposition. Moving forward, the legislation's prospects in the Senate remain uncertain, primarily because the CR provides for a full year funding for the Department of Defense, while funding non-defense programs only until March 23, 2018. In addition, immigration issues are not addressed in this CR, which may complicate matters further. Congress must extend government funding by February 8, 2018 to avert another federal government shutdown.

Background and Analysis

The CR includes extensions of a number of Medicare and other health programs and policies that have been considered or passed out of the House or the Senate. Most of the extensions run for two years, but some run for five years.

Key health care provisions included in the CR are outlined below.

Medicare Extenders and Related Policies:

- Permanent repeal of the Medicare payment cap for therapy services beginning on January 1, 2018, and a lower threshold for the targeted manual medical review process from $3,700 to $3,000.
- Five-year extension of the 2-percent urban, 3-percent rural, and 22.6-percent super rural ground ambulance add-on payments until December 31, 2022. The provision would require annual cost reporting by adding providers and suppliers of ground ambulance suppliers as a new category.
- Two-year straight extension of the Geographic Practice Cost Indices (GPCI) floor until January 1, 2020.
- Two-year straight extension of the Medicare-dependent hospital (MDH) program until October 1, 2019.
- Two-year straight extension of the increased inpatient hospital payment adjustment for certain low-volume hospitals until October 1, 2019.
- Five-year extension with reforms of the home health rural add-on until October 1, 2022. The reforms include a new methodology to target the add-on payment to those areas with a population density of six or fewer individuals per square mile.
- Permanently reauthorizes Medicare Advantage (MA) Special Needs Plans (SNPs) for vulnerable populations, along with a number of reforms to Dual-Eligible SNPs (D-SNPs) and Chronic Condition SNPs (C-SNPs) to improve care management.

- Two-year extension of funding for quality measure endorsement, input, selection, and reporting requirements.
- Requirement for the HHS Secretary to reform the current home health payment system and implement a 30-day episode for payment, beginning January 1, 2020. This change is required to be budget neutral.
- Includes technical corrections to the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):

  - Changes the inclusion of "items and services" to clarify the limitation to "covered professional services;"
  - Allows the Centers for Medicare and Medicaid Services (CMS) flexibility in applying the 30 percent resource use performance score for three additional years;
  - Allows CMS three additional years to ensure a gradual and incremental transition to the performance threshold; and
  - Makes updates to the ability of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to further aid the development of physician led alternative payment models.
- Makes coverage of speech generating devices under durable medical equipment permanent under the Medicare program (removing the 2018 sunset under current law).
- Codifies beneficiary protections and provides for enhanced reporting for Congress and CMS to ensure beneficiaries are receiving the diabetic testing supplies they need to manage their condition.

CHRONIC Care Act:

- Allows providers to utilize telehealth for home dialysis patients.
- Expands the testing of the CMMI Value-Based Insurance Design Model to allow MA plans in any state to participate in the model by 2020.
- Allows MA plans to offer a wider array of targeted supplemental benefits to chronically ill enrollees beginning in 2020.
- Allows MA plans to offer additional, clinically appropriate, telehealth benefits in their annual bid amounts beyond the services that currently receive payment under Part B beginning in 2020.
- Provides Accountable Care Organizations (ACOs) the ability to expand the use of telehealth services.
- Expands the use of telehealth for individuals with stroke beginning in 2021.
- Allows Medicare ACOs the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. In addition, beneficiaries would have the option to voluntarily align to an ACO in which the beneficiary's main primary care provider is participating.
- Establishes a new voluntary ACO Beneficiary Incentive Program, which would allow certain two-sided risk ACOs to make incentive payments to all assigned beneficiaries who receive qualifying primary care services.

Medicare Part B Improvement Act:

- Creates a temporary transition service and education Medicare payment for home infusion beginning in 2019.
- Allows dialysis providers to seek outside accreditation, from organizations approved by Medicare, in order to be able to bill Medicare for end-stage renal disease (ESRD) services.
- Codifies into law CMS's recent changes to Stark law regulations relating to when leases were in violation of the Stark laws and when signatures were required to document the terms of legal arrangements.

Public Health Extenders:

- Extends funding for community health centers for two years and implements technical and programmatic changes.
  - Combined with funding provided in the December CR (H.R. 1370), community health centers will receive $3.6 billion for each of FY18 and FY19.
- Extends funding for two years for the National Health Service Corps and the Teaching Health Center Graduate Medical Education Program.
  - Combined with funding provided in the Disaster Tax Relief Act (H.R. 3823) and H.R. 1370, for each of FY18 and FY19, the National Health Service Corps will receive $310 million and the Teaching Health Center Graduate Medical Education Program will receive $126.5 million.
- Extends funding for the Special Diabetes Program for Type 1 Diabetes and the Special Diabetes Program for Indians for two years.
  - Combined with funding provided in H.R. 3823 and H.R. 1370, each of these programs will receive $150 million for each of FY18 and FY19.
- **Note:** The bill does not include funding for the Maternal, Infant, and Early Childhood Home Visiting Program.

Key health-related fiscal offsets to provide for the package are outlined below.

- Modifies payments for early discharges to hospice care.
- Requires the FY20 market basket update for home health agencies to be 1.4 percent (in the absence of this provision, the home health market basket would be higher).
- Reduces pay for non-emergency ambulance transports of kidney patients.
- Extends the target for relative value adjustment for misvalued codes for one more year.
- Delays CMS's authority to terminate contracts for certain MA plans through the ten-year budget window.
- Rescinds unspent money from the Medicare and Medicaid Improvement Funds.
- Reduces pay for outpatient physical and occupational therapy services furnished by a therapy assistant to 85 percent of the rate that would have otherwise been paid for by a physician.
- Reduce long term care hospital (LTCH) payments by delaying the current law blended payment rate for two years and reverting back to the FY17 blended rate of 50-percent site neutral and 50-percent LTCH. In addition, the provision reduces the LTCH market basket update for FY18 through FY26 by 4.6 percent.
- Change Medicaid and CHIP's third-party liability requirements.
- Requires state Medicaid programs to count lottery winnings for determining an individual's income eligibility under Medicaid.
- Eliminates the Medicaid Disproportionate Share Hospital (DSH) reductions scheduled for FY18 and FY19 under current law. The DSH reduction of $4 billion in FY20 under current law remains and the bill adds a total of $6 billion in additional DSH reductions to offset the cost of eliminating the FY18 and FY19 reductions, allocated as follows: $3 billion in FY21, $2 billion in FY22, and $1 billion in FY23.
- Includes biosimilars in the Medicare Part D coverage gap discount program.
- Modifies funding in the ACA's Prevention and Public Health Fund to the following amounts:
  - FY18 and FY19: $900 million
  - FY20 and FY21: $1 billion
  - FY22 through FY27: $1.1 billion

We will provide further updates on subsequent action in the Senate on the government funding measure as developments unfold.