

Government Relations Summary: Balanced Budget Act of 2018

After a brief government shutdown, on February 9, 2018, the Senate and House passed the *Bipartisan Budget Act* ([BBA18, Public Law 115-123](#)), funding the government through March 23, 2018. The spending package was strongly bipartisan, passing in the Senate 71-28 and in the House 245-182. The bill includes many important health provisions, and the AAFP released a [statement](#) from Dr. Michael Munger, AAFP President, praising many aspects of the bill prior to its passage. The AAFP also joined five other frontline physician organizations in releasing a [joint statement](#) urging the bill's passage. AAFP also joined a [letter](#) urging that Congress not extend the misvalued codes policy into 2019, and that the work GPCI floor be extended. Both of these requests were fulfilled in the bill.

This most recent extension of funding came less than two weeks after a prior brief government shutdown, which ended after President Trump [signed](#) another short-term spending bill ([PL 115-120](#)). This prior law had included a six-year reauthorization of the Children's Health Insurance Program (CHIP) as well as two-year delays to the medical device tax and the "Cadillac" tax on high-cost health plans and a one-year delay for the health insurance tax imposed by the *Affordable Care Act* (ACA).

The following is a high-level summary of several of the BBA18's key health care provisions.

Medicare's Geographic Practice Cost Index (GPCI) floor (Section 50201)

- Congress established a temporary floor for the work GPCI in the Affordable Care Act, which suspends its impact in localities where labor cost is determined to be lower than the national average (predominantly outside of urban areas). The section extends the current 1.0 physician work GPCI floor for two years through December 31, 2019. Although Congress allowed the floor to expire on January 1, 2018, the extension is drafted to be retroactive to January 1. It is not clear yet, however, how CMS plans to reprocess claims already filed by physician practices that were impacted by the lapse of the policy, for services rendered on or after January 1.

The Primary Care Cliff (Section 50901)

- Extends funding for Teaching Health Center (THC) Graduate Medical Education for two years at an annual level of \$126.5 million which more than doubles the prior annual funding. The section requires the Secretary to report to Congress on the number of patients and patient visits treated by residents as well the number of residents who go on to serve in rural or health professional shortage areas or medically underserved communities. In addition, this section calls for a report to Congress on the direct and indirect expenses associated with training residents at THCs. In awarding grants to establish new THCs, this section directs the Secretary to prioritize THCs in a rural area or serve a health professional shortage area or a medically underserved community.
- Community health centers funding is authorized for 2 years (\$3.8 billion for FY2018; \$4 billion for FY2019).
- The National Health Service Corps is level-funded at \$310 million for two years.

Technical Amendments to the Merit-Based Incentive Payment System (MIPS) program (Section 51003)

- Removes improvement as an element of scoring for the cost performance category for the third, fourth and fifth years of MIPS (physicians will be judged on achievement alone);
- Allows CMS to reduce the weight of the cost performance category to 10 percent for the third, fourth, and fifth years of MIPS (the floor was set to rise to 30 percent on January 1, 2019);

AAFP Headquarters

11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aaafp.org

AAFP Washington Office

1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aaafp.org

- Allows CMS flexibility in setting the performance threshold for years three through five, which gives the CMS authority to extend the “Pick your Pace” reporting program through the end of 2021;
- Excludes Medicare Part B drug costs for MIPS adjustments and low-volume threshold determination;
- Requires CMS to post resource-use measures on the Internet by December 31, 2018 (and in each later year). Many cost measures are not mature and physicians must have an opportunity to review them.
- Give the Physician-Focused Payment Model Technical Advisory Committee (PTAC) new authority to provide more feedback and assistance to stakeholders seeking review of physician-focused APMs.

EHR Significant Hardship (Section 50413)

Removes the legislative requirement that CMS measures and activities under the Meaningful Use program (now called Advancing Care Information) become “more stringent” over time. This helps prevent new practice burdens on physicians in the use of their electronic health records software.

Further Budget Agreement Aspects

The BBA18 sets overall funding caps for future appropriations. As part of the deal, but not explicitly included in the law’s legislative language, BBA18 is said to allow for the following increased federal resources:

- \$6 billion in funding for the opioid crisis and for mental health and substance use disorder treatment;
- \$4 billion to rebuild and improve Veterans Administration hospitals and clinics; and
- \$2 billion in new funding for NIH research.

Children’s Health Insurance Program (CHIP) (Section 50501)

CHIP is extended for an additional four years beyond the previous Continuing Resolution’s six-year extension, with appropriations made through 2027. The section also extends the Child Enrollment Contingency Fund, the Qualifying States Option, the Express Lane Eligibility option, and continues to require states to maintain eligibility levels (the “Maintenance of Effort” provision) for CHIP children through FY2027.

Emergency Medicaid Funds for Puerto Rico and the U.S. Virgin Islands (Section 20301)

Puerto Rico’s Medicaid caps for 2018 – 2019 are increased by an additional \$4.8 billion. The Virgin Islands’ caps are increased over the same period by \$142.5 million. Also, 100 percent federal cost sharing for Medicaid is provided for both through September 30, 2019.

Independent Payment Advisory Board (IPAB) Repeal (Section 52001)

Permanently repeals the Independent Payment Advisory Board (IPAB).

Medicare payment cap for therapy services (Section 50202)

Permanently repeals Medicare’s therapy caps beginning on Jan. 1, 2018. These caps applied to outpatient therapy services, including physical therapy, speech language pathology services, and occupational therapy. Physicians will still be required to add a modifier on claims to approve medically necessary services above the current exception threshold.

Addressing the “Donut Hole” for Seniors (Sections 53116 and 53113).

Closes the Medicare Part D prescription drug “donut hole” sooner than under current law by increasing the discounted price manufacturers provide from 50 percent to 70 percent. Also allows the coverage gap discount program to apply to biosimilars, decreasing the out of pocket cost for seniors in Part D.

Delays cuts in Medicaid Disproportionate Share Hospital (DSH) payments (Section 53101)

The ACA assumed all states would expand Medicaid, called for decreases to payments for hospital with disproportionately large uninsured populations. Under current law, disproportionate share hospital (DSH) payments are scheduled to be reduced starting in FY2018. This provision eliminates the DSH reductions in FY2018 and FY2019, maintains the \$4 billion in reductions for FY2020, and sets the amount of reductions for FY2021 through FY2025 at \$8 billion per year.

Funding for the National Quality Forum (Section 50206)

Extends funding through CMS for the National Quality Forum by \$7.5 million for each of FY2018 and 2019.

Medicare Home Health Eligibility (Section 51002)

Physicians will no longer be required to fill out exhaustive paperwork to qualify patients for Medicare home health services. CMS would determine eligibility for home health services through a review of the patient medical record, including the home health agency's record. In places where the physician's record may be insufficient to confirm eligibility, the home health agency's record may be used as supporting material to attest eligibility for home health services.

Special Diabetes Programs (Section 50902)

Extends funding for both the Special Diabetes Program for Type 1 Diabetes and the Special Diabetes Program for Indians at the current level of \$150 million for each of FY2018 and 2019.

Extension for Sexual Risk Avoidance Education (Section 50502)

Provides funds to states to provide education exclusively focused "abstinence only" education.

Extension for Personal Responsibility Education Program (Section 50503)

PREP provides grants to implement evidence-based, or evidence-informed, innovative strategies for teen pregnancy and HIV/STD prevention, youth development, and adulthood preparation. BBA18 extends PREP through FY2019 and expands the target population to include youth who are victims of human trafficking.

Maternal, Infant and Child Home Visiting Program (Sections 50601-50607).

Continues MIECHV at the current level of \$400 million per year for FY2018-2022. This program provides states, territories, and tribes with grants to support evidence-based home visiting programs for at-risk families.

Health workforce demonstration projects for low-income individuals (Section 50611)

Extends current funding for the Health Workforce Demonstration Project to help low-income individuals obtain education and training in high-demand health care jobs, through FY2019.

Access to hospice care (Section 51006)

Clarifies that, as with nurse practitioners, physician assistants (PAs) cannot certify or recertify hospice care for individuals. This section would permit PAs to serve as the attending physician for hospice, which allows them to manage and separately bill for hospice care. This section would also enable PAs to act as the attending physician to establish, and periodically review, the hospice plan of care to ensure care is provided pursuant to the plan of care.

Supervision requirements for outpatient therapy services in rural hospitals (Section 51007)

Extends a Medicare rule allowing certain outpatient therapeutic services furnished in critical access hospitals and other small rural hospitals be provided under the direct supervision of a physician in the hospital. As a result, a physician or non-physician practitioner will not need to be immediately available to assist and direct throughout the performance of a procedure.

Funding offsets include:

2019 Medicare Physician Fee Schedule positive update (Section 53106)

Reduces the statutory positive update to the Medicare Physician Fee Schedule conversion factor for 2019 from 0.5 percent to 0.25 percent.

Prevention and Public Health Fund (PPHF) (Section 53119)

Reduces funding for the PPHF by \$1.35 billion between FY2018 – 2027.