



The Bipartisan Budget Act of 2018: Key Provisions and Policies for People with Medicare

On February 9, Congress passed and the President signed a sweeping spending bill that will fund the government through March 23 and raise the spending caps imposed by the Budget Control Act of 2011 for two years, paving the way for a longer-term spending agreement. The legislation—the Bipartisan Budget Act of 2018 ([P.L. 115-123](#), BBA of 2018)—also suspends the government’s cap on borrowing through March 2019, and contains a number of health care provisions important to people with Medicare and their families.

Below, please find the Medicare Rights Center’s preliminary analysis of the BBA of 2018, which focuses on changes to Medicare and other programs serving older adults and people with disabilities, including 1) **Appropriated Programs**, 2) **Health Care Extenders and Policies**, 3) **The CHRONIC Care Act**, 4) **Excluded Priorities**, 5) **Offsets**, and 6) **Next Steps**.

1) Appropriated Programs

The budget deal raises the limits on defense and non-defense appropriations in Fiscal Years 2018 (FY18) and 2019 (FY19) that were set by the 2011 Budget Control Act and subsequently reduced further by the sequestration process. The agreement follows three bipartisan deals of recent years raising those caps, each of which reflected the reality that post-sequestration appropriations caps were simply too low to meet national needs. This agreement provides the largest increase in the series, raising the non-defense cap by \$63 billion in FY18 and \$68 billion in FY19. While this relief is welcome, it’s notable that even with this boost, overall funding for non-defense appropriations—which support key aging and health priorities outside of Medicare—will remain below 2010 levels after adjusting for inflation.

Congress now has until March 23—when the current funding authorization expires—to pass another spending bill. The hope is that the extra funding and time provided by the BBA will allow appropriators to reach a longer-term, comprehensive deal and fund the government for the remainder of FY18, which ends September 30. However, several policy and fiscal debates remain unresolved, raising the possibility that another stopgap—the sixth this year—may be necessary.

Though the timeline for a final package may shift, as appropriators make decisions about what programs to fund and by how much, the Medicare Rights Center will continue to advocate for investments in key services on which older adults, people with disabilities, their families, and caregivers rely.

2) Health Care Extenders and Policies

The agreement also funds a host of more limited health care initiatives—some of which are known as “extenders” because they are often attached to other, larger health or spending bills. Among the policy and funding changes in the BBA of 2018 are renewals of lapsed or expiring programs, as well as permanent and temporary policy fixes, including the following Medicare and non-Medicare extenders:

Health Care Extenders and Policies: Medicare

Funds Medicare Outreach and Enrollment Activities. The package extends funding for community-based organizations to conduct outreach and enrollment of low-income Medicare beneficiaries into the Part D Low-Income Subsidy Program (LIS/Extra Help) and Medicare Savings Programs (MSPs) and to promote utilization of Medicare's preventive services. Originally authorized in 2008 by the Medicare Improvement for Patients and Providers Act (MIPPA), the BBA of 2018 renews this funding for two years at current levels of \$37.5 million.

Closes the “Donut Hole” Faster. The bill accelerates changes the Affordable Care Act (ACA) made to provide some relief to Medicare beneficiaries with high prescription drug costs who hit a gap in Part D coverage known as the “donut hole.” Prior to the ACA, beneficiaries in the coverage gap had to pay the full cost of their drugs, an impossible burden for many. The health law took steps to phase out the donut hole by 2020 through a series of escalating contributions from health plans and drug manufacturers. Under the budget deal, starting in 2019, certain drug manufacturers will be required to give larger discounts to beneficiaries in the coverage gap, while the plan responsibility will shrink. This change will close the donut hole next year, one year ahead of schedule.

Repeals Outpatient Therapy Caps. The bill permanently repeals the limit on Medicare's coverage of physical therapy, speech-language pathology, and outpatient treatment. Since the Bipartisan Budget Act of 1997, outpatient therapy under Medicare Part B has been subject to annual caps. But Congress has long taken action to delay those caps or provide exceptions to prevent them from fully taking effect. The BBA of 2018 permanently repeals the caps, but continues to require providers to attach the KX modifier code to claims above \$2,010 (adjusted annually) to indicate the services are medically necessary. Claims above a higher limit (\$3,000) may be subject to a targeted manual medical review. Notably, prior to the BBA of 2018, the threshold for targeted medical review was \$3,700. However, CMS did not receive any increased funding to pursue expanded reviews under the lower threshold, and the overall number of targeted reviews is not expected to increase as result of this provision. Nearly [six million](#) people with Medicare used outpatient therapy services in 2015.

Changes the Home Health Benefit. The bill makes changes to the Medicare home health benefit, in part by reducing the unit of payment for a home health episode from 60 days to 30 days, beginning in 2020, and by eliminating the use of therapy thresholds that CMS uses to make case-mix adjustments to home health payments. It also modifies the eligibility determination process for home health services. Beginning in 2019, Medicare will be allowed to base eligibility determinations for home health services on a review of the patient's medical record, including documentation in the home health agency records.

Makes Coverage of Speech Generating Devices Permanent. The BBA of 2018 includes the Gleason Enduring Voices Act ([S. 1132](#), [H.R. 2465](#)). This bill builds upon the successes of the Steve Gleason Act of 2015, scheduled to sunset in 2018. In part, it makes Medicare coverage of speech generating devices (SGDs) permanent, and amends the Durable Medical Equipment (DME) section of the Social Security Act to ensure that Medicare beneficiaries can access their SGD across settings, and for as long as necessary.

Health Care Extenders and Policies: Non-Medicare

Extends the Children's Health Insurance Program. The bill also includes a four-year extension of the Children's Health Insurance Program (CHIP), from 2024 through 2027. This is on top of a six-year extension that Congress approved last month as part of a broader continuing resolution to fund the federal government. CHIP provides affordable health coverage for over 9 million children and gives

working families—many of which include people with Medicare—much-needed health and economic security.

Funds Community Health Centers. The budget bill includes \$7 billion over two years for the nation’s community health centers, whose federal support lapsed on September 30, 2017. These [10,000 facilities](#) across the country provide primary care to an estimated 26 million Americans, including nearly [2.4 million](#) medically underserved Medicare beneficiaries. Currently, people with Medicare make up [9%](#) of all health center patients nationally.

Funds Other Health Priorities. The budget agreement also funds a number of other health-related priorities. It includes an additional \$6 billion for fighting opioid addiction and boosting mental health services, \$4 billion to improve health care for veterans, and \$2 billion to support additional research at the National Institutes of Health. It also provides \$90 billion in disaster assistance for California, Texas, Florida, Puerto Rico, and the U.S. Virgin Islands.

It also seeks to address workforce and public health issues by funding programs that encourage doctors to practice in medically underserved areas. It allocates just under \$500 million over the next two years for the National Health Service Corps and another \$363 million over two years to the Teaching Health Center Graduate Medical Education program, which places medical residents in Community Health Centers.

3) The CHRONIC Care Act

The BBA of 2018 includes all provisions of the bipartisan Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act ([S. 870](#)). Introduced by leaders of the Senate Committee on Finance—Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR)—the CHRONIC Care Act unanimously passed the Senate in 2017. A key focus of the Act is on improving and expanding services and coverage in Medicare Advantage (MA) for beneficiaries with complex medical conditions.

Expands Supplemental Benefits in Medicare Advantage. The CHRONIC Care Act expands the array of supplemental benefits MA plans may offer to chronically ill beneficiaries, beginning in 2020. Under current CMS guidance, supplemental benefits must, among other things, be primarily health related. The expanded supplemental benefits, however, will not be subject to this limitation. Rather, such services must only have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill beneficiary. This flexibility is expected to allow plans to address non-clinical needs such as transportation, food, and home modifications.

Makes Special Needs Plans Permanent. MA Special Needs Plans (SNPs) were set to expire at the end of 2018; this bill makes them permanent. First established by Congress in 2003, SNPs have been periodically extended ever since. They serve targeted populations and include plans for beneficiaries eligible for both Medicare and Medicaid (D-SNPs), those residing in medical institutions (I-SNPs), and those with chronic illnesses (C-SNPs).

This provision also makes a number of reforms designed to improve care management. Among the changes are requirements for enhanced coordination between states and the federal government for D-SNPs—especially with regard to appeal and grievance protocols—and requiring these plans to have direct contracts with the states in which they operate. C-SNPs will also see changes. Starting in 2020,

care management strategies employed by these plans will be subject to heightened standards, and CMS will be required to update the list of qualifying chronic conditions C-SNPs can target every five years.

Renews Independence at Home. The CHRONIC Care Act also extends the Independence at Home (IAH) [demonstration program](#) for two years, and increases the number of beneficiaries that can be included in the program from 10,000 to 15,000. Created by the ACA and conducted by the Center for Medicare and Medicaid Innovation (CMMI) within CMS, the IAH demonstration is testing whether providing home-based primary care to Medicare beneficiaries with multiple chronic conditions and functional limitations can improve outcomes and lower costs. Providers that lower expenses are rewarded with a portion of the savings.

Expands the V-BID Model. The BBA of 2018 expands the Value-Based Insurance Design (V-BID) Model to MA plans in all states by 2020. Under this [pilot](#), also operated by CMMI, plans may offer supplemental benefits or reduced cost sharing to enrollees with specific chronic conditions, focused on services that are of highest clinical value to them. With the V-BID model, CMS is testing whether this approach can improve health outcomes and lower costs for beneficiaries.

Increases ACO Flexibilities. The bill includes several changes intended to allow Accountable Care Organizations (ACOs) to better meet beneficiary needs. An ACO is a network of doctors, hospitals, and other health care providers that share financial and medical responsibility for providing coordinated care to patients—and become eligible for bonuses when they deliver that care more efficiently. Medicare offers several ACO models, including one under the ACA-created Medicare Shared Savings Program (MSSP). MSSP ACOs agree to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service beneficiary population.

Currently, Medicare beneficiaries are assigned to MSSP ACOs based on where they receive their primary care services. According to ACOs, this so-called “retrospective assignment” of beneficiaries can make it difficult to proactively design care plans for their cohort. The CHRONIC Care Act attempts to solve this by allowing MSSP ACO models to elect to have their beneficiaries assigned prospectively at the beginning of a performance year. In addition, the bill gives beneficiaries the option to align to the MSSP ACO in which their primary care provider is participating. Under existing program rules, beneficiaries can’t directly choose to participate in an ACO. Instead, they are notified if their primary care provider is an ACO participant.

The BBA also establishes a new, voluntary ACO Beneficiary Incentive Program under which certain ACOs will be allowed to make cash incentive payments to beneficiaries who receive qualifying primary care services. Eligible ACOs may offer up to \$20 per service, payable directly to the beneficiary. The payments would be funded by the ACOs themselves and are not reimbursable by Medicare.

Expands Telehealth and Other Technologies. Several sections of the legislation are dedicated to expanding access to telehealth in Medicare Advantage. Currently, Medicare limits the availability of these services to beneficiaries who receive the treatment at certain sites (like a hospital or a physician’s office) located in rural areas. The bill eliminates geographic restrictions for some services and also includes the following new flexibilities:

- **ESRD Patients**—Beginning in 2019, Medicare beneficiaries with end-stage renal disease (ESRD) on home dialysis may receive their required monthly clinical assessment via telehealth at home

or a dialysis center, without any geographic restrictions. Patients must still receive a face-to-face visit for the first three months, and once every three months thereafter.

- **Telestroke**—Also beginning in 2019, the Act will expand stroke telemedicine coverage by eliminating the geographic restrictions on telestroke consultation services.
- **MA Plans**—The bill allows MA plans to include telehealth services as a basic benefit. While MA plans can currently offer additional, clinically appropriate telehealth benefits beyond those covered under Part B as a supplemental benefit, beginning in plan year 2020, they will be able to build these services into their base premium bids. The BBA instructs the U.S. Department of Health and Human Services to solicit public comments and develop guidance on this expansion.
- **ACOs**—The bill enables Accountable Care Organizations (ACOs) to expand the use of telehealth services. Beginning in 2020, the beneficiary’s home will qualify as an eligible originating site for telehealth services provided by a physician or practitioner in certain ACOs, regardless of geographic location.

Directs New GAO Studies. There are three mandatory Government Accountability Office (GAO) reports in the Act, signaling that Congress may be interested in these issues, but not yet prepared to offer legislative solutions.

- **Comprehensive Care Planning Services Under Medicare Part B**—The first report would assess the potential development of a new reimbursement code for formulating comprehensive care plans for beneficiaries diagnosed with a serious or life-threatening illness.
- **Improving Medication Synchronization**—The second GAO report would examine medication synchronization programs that attempt to align the dates on which beneficiaries with multiple prescriptions are required to pick up the 30-day fills for their respective medications.
- **Impact of Obesity Drugs on Patient Health and Spending**—The third report would investigate the potential inclusion of obesity-related drug therapies in Medicare Part D, where they are currently banned.

4) Excluded Priorities

Several of the Medicare Rights Center’s priorities were not included in the package. We will continue to support these changes and advocate in particular for the inclusion of the BENES Act in the March 23 spending bill:

Simplifying Medicare Part B Enrollment. The budget deal does not include the bicameral, bipartisan Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act ([S. 1909](#); [H.R. 2575](#)), which would simplify, modernize, and improve the Medicare Part B enrollment process. The bill’s common sense reforms are championed by Todd Young (R-IN) and Bob Casey (D-PA) in the Senate and Representatives. Raul Ruiz (D-CA) and Patrick Meehan (R-PA) in the House. While disappointed the BENES Act was not included in the BBA of 2018, we continue to advocate for swift passage. We invite you to join us in this effort. Please [click here](#) to weigh in with your lawmakers today.

Extending Money Follows the Person. Nor does the budget deal extend the Money Follows the Person (MFP) program, which expired on September 30, 2016. Since it launched in 2007, MFP has helped more than [75,000 people](#) with Medicaid—many of whom also rely on Medicare—transition from nursing facilities to community-based settings. Bipartisan legislation ([S. 2227](#)) from Senators Portman (R-OH) and Cantwell (D-WA) would extend the program for five years. We urge lawmakers to extend the MFP program without delay.

Stabilizing the Health Care Market. Also of note, the legislation does not include bipartisan legislation to address ongoing uncertainty in the individual insurance market, as was once expected. The Medicare Rights Center continues to support efforts to meaningfully strengthen the nation’s health care system.

5) Offsets

To help pay for, or offset, the bill’s funding and policy changes, the BBA of 2018 includes a variety of program cuts. Of particular concern to the Medicare Rights Center are pay-fors that would undermine Medicare or jeopardize access to quality health care, including the following:

Increased Medicare Premiums. Troublingly, the BBA of 2018 increases Medicare Part B and Part D premiums for some beneficiaries, further means testing the program. Beginning in 2019, individuals with incomes over \$500,000 a year (\$750,000 for couples) will be required to pay 85% of program costs, up from 80% under current law. [Read more](#) from Medicare Rights about this change.

Extending the Medicare Sequester. The deal includes another two-year extension of the Medicare sequester. Approved in 2011 as part of the Budget Control Act (BCA)—the same legislation that established caps on federal discretionary spending—the Medicare sequester didn’t take effect until 2013. Since then, Congress has extended it several times, usually to pay for increases in the BCA’s federal budget caps. It was last extended through 2025 but now will continue through 2027. The Medicare sequester imposes a 2%, across-the-board cut to provider reimbursements.

Cutting the Prevention and Public Health Fund. The bill cuts the Prevention and Public Health Fund (PPHF) by \$1.35 billion over ten years, beginning in 2024. The PPHF was established by the Affordable Care Act to support public health, wellness, and prevention initiatives that improve outcomes and control costs. Over the years the PPHF has made important investments in programs such as falls prevention and chronic disease self-management.

Other Health-related Offsets. Among the bill’s other savings are a revision of the physician fee schedule, a policy that reduces hospital Medicare payments when the hospital transfers a patient to hospice after just a short stay, and a policy to block artificial inflation of star ratings of various Medicare Advantage plans in the case of insurers’ consolidation. The bill also rescinds unspent money from the Medicare and Medicaid Improvement Funds and includes biosimilars in the Medicare Part D coverage gap discount program.

6) Next Steps

The budget deal makes a number of complex changes to federal health programs, and it’s not yet clear how these revisions will interact. Accordingly, the Medicare Rights Center will stay engaged with lawmakers and the administration to ensure these policies are implemented in a way that prioritizes older adults and people with disabilities.

Most immediately, as appropriators work to finalize FY18 spending levels, the Medicare Rights Center will continue to advocate for adequate funding for programs important to people with Medicare and their families. We also urge Congress to extend MFP and strongly support the inclusion of the BENES Act in this upcoming package. [Click here](#) to weigh in with your lawmakers today!