

MEHLMAN CASTAGNETTI

— ROSEN & THOMAS —

To: American Society of Echocardiography

From: Mehlman Castagnetti Rosen & Thomas

Re: Major Health Provisions in the February 2018 Government Funding Bill

Date: February 16, 2018

Background

On Friday, February 9, President Trump signed another temporary funding bill to keep the government open after a brief shutdown overnight. While Senate Leadership had intended to fast-track a vote on the bill and send it to the House before the midnight deadline on February 8, Senator Rand Paul (R-KY) – who had been critical of the spending increases in the bill - delayed the vote, which ultimately resulted in a government shutdown for a few hours. A little before 2:00am on Friday, February 9, the Senate voted 71-28 to pass the bill and send it to the House, where it passed 240-186 around 5:30am that morning.

The legislation funds the federal government through March 23, and includes a budget cap agreement that would raise the cap on federal spending for defense and domestic programs by \$296 billion over two years. Congressional appropriators will use the time between now and March 23 to appropriate the funding that will be included in the longer-term omnibus package, using the BCA deal as a guide. A full section-by-section summary of the health provisions in the bill can be found [here](#), although a brief overview of these major health provisions is as follows:

- Extends the reauthorization of funding for the Children's Health Insurance Program (CHIP) through 2027.
- Provides \$7 billion for Community Health Centers (authorizes the program for two years).
- Provides \$6 billion in additional funding to combat the opioid epidemic.
- Provides Congress with \$2 billion in budget authority to increase funding for the National Institutes of Health (NIH).
- Repeals the Independent Payment Advisory Board (IPAB).
- Permanently repeals outpatient therapy services payment caps.

The funding bill also included key provisions from the Senate Finance Committee's bipartisan bill, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act (or CHRONIC Care) of 2017. Several provisions regarding telehealth and impacting the dialysis community were also included.

Expanded Access to Medicare Intensive Cardiac Rehabilitation Programs

This provision expands access to intensive cardiac rehabilitation (ICR) programs for beneficiaries who have stable, chronic heart failure and any future condition for which cardiac rehabilitation is covered, unless the Secretary determines coverage is not supported by clinical evidence.

Supervision of Cardiac, Intensive Cardiac, and Pulmonary Rehabilitation Programs

Under current law, only a physician may supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs. This provision revises current law by also allowing a physician assistant, nurse practitioner, or clinical nurse specialist to supervise such programs, beginning January 1, 2024.

MACRA's Merit-Based Incentive Payment System

This provision is intended to improve the application of the Merit-based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 by making the following changes:

- Limiting the application of the performance-based payment adjustment to services paid under the physician payment schedule (consistent with performance incentive programs that came before MIPS);
- Ensure that the metrics for assessing resource use are relevant and fair; and
- Allowing CMS to more gradually raise the threshold on which total performance is assessed.

This provision also allows the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback to stakeholders regarding alternative payment models submitted for consideration.

Providing Accountable Care Organizations the Ability to Expand Telehealth Use

This provision permits Accountable Care Organizations (ACOs) with expanded use of telehealth using the Next Generation ACO waiver criterion. This provision applies to the following ACOs:

- Medicare Shared Savings Program (MSSP) Track II (only if an ACO chooses prospective assignment and remains at two-sided risk)
- MSSP Track III
- Two-sided risk ACO models with prospective assignment that are tested or expanded through CMMI

Specifically, this provision would:

- Eliminate the geographic component of the originating site requirement;
- Allow beneficiaries assigned to the approved MSSP and ACO programs to receive currently allowable telehealth services in the home; and
- Ensure that MSSP and ACO providers are only allowed to furnish telehealth services as currently specified under Medicare's physician fee schedule, with limited exceptions.

Stark Rule Modernization

This provision codifies the recent regulatory changes made by the Centers for Medicare & Medicaid Services (CMS) to the federal physician self-referral law (Stark law). The original intent of the Stark law is to prevent Medicare physician's financial interests from interfering with clinical decisions. The changes made by CMS (which were included in the Agency's annual 2017 Medicare Physician Fee Schedule update and were effective January 1, 2018), modified the regulation in terms of when leases violated the law and also when a signature was required to document legal arrangement terms.

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Repeal of the Independent Payment Advisory Board

This provision repeals the Independent Payment Advisory Board (IPAB), which was established under the Affordable Care Act (ACA) in 2010. Although none of the 15 members were ever formally appointed or Senate confirmed, the ACA gave the board the authority to make payment and program changes to Medicare if the Centers for Medicare & Medicaid Services (CMS) projected that the program was going to exceed its target growth rates. The IPAB has drawn criticism from both sides of the aisle because of the board's authority to make payment and program changes to the Medicare program without Congressional approval. Although the Medicare Payment Advisory Commission (MedPAC) similarly makes recommendations about changes to payment rates and program rules under Medicare, the IPAB differs in that MedPAC's recommendations are non-binding and still require an act of Congress in order for them to take effect. The non-partisan Congressional Budget Office (CBO) [projects](#) that repealing the IPAB will increase mandatory spending by approximately \$17.5 billion.

Site Neutrality

This provision extends the "blended" site neutral payment rate (which, for fiscal year 2018, is a blend of the 75% site neutral payment rate and the 25% long-term care hospital rate) for certain long-term care hospital discharges through 2019. This provision also temporarily adjusts to site neutral payment rates to revert back to the fiscal year 2017 blended rate (which was 50% site neutral and 50% long-term care hospital). The provision also reduces the long-term care hospital market basket update by 4.6% for fiscal years 2018 through 2026.