February 23, 2018

Health Care Provisions in Bipartisan Budget Act of 2018

On Friday, February 9, President Trump signed The Bipartisan Budget Act of 2018 (the "2018 Act") into law. Among other things, the 2018 Act makes changes to the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), revises some provisions of the Affordable Care Act ("ACA"), and provides funding for various federal health care programs. This Alert details some of the most notable provisions for health care industry stakeholders.

Changes to MACRA's Merit-Based Incentive Payment System ("MIPS") and Physician Fee Schedule

In 2015, MACRA was signed into law, ending years of annual "doc fixes." MACRA adopted a two-track Quality Payment Program, replacing the plagued sustainable growth rate formula for setting the Medicare Part B physician fee schedule. One of the MACRA tracks establishes the so-called Advanced Alternative Payment Models, or "APMs." That is unchanged by the 2018 Act. The 2018 Act's changes focus on the so-called Merit-based Incentive Payment System, or "MIPS," which is the "default" track under MACRA. MIPS scores participating clinicians based on performance in four domains (quality, advancing care information, improvement activities, and cost). Under MACRA, Medicare Part B reimbursement for participating clinicians is adjusted up or down according to weighted scores in these four categories. The 2018 Act changes scoring and weighting within MIPS. In addition to changes to MIPS, the 2018 Act reduces the annual increase established by MACRA for the physician fee schedule. Specifically, the 2018 Act provides for:

- **CMS Flexibility to Reduce Weighting of the Cost Domain.** MACRA originally intended for cost, while disregarded in the first year, to account for 30% of performance scores by 2021. The 2018 Act provides CMS with discretion to determine the weight of the cost domain for years two through five of MIPS, provided that CMS stays within a band of 10%–30%. Conceivably, the cost domain could remain as low as 10% through 2021. This change responds to stakeholder concerns that the cost domain relied on problematic data and flawed methodologies, and that the domain required additional review and alteration by CMS before comprising a larger percentage of the MIPS score.

- **Elimination of Part B Drugs and Other Separately Billed Items from MIPS Cost Domain and MIPS Eligibility Determinations.** The 2018 Act excludes separately billed items—including Medicare Part B drugs—from associated MIPS calculations and thus from MIPS payment adjustments. Since drugs and other separately billed items can be a significant driver of cost, this change will have a major impact on clinicians who bill Medicare Part B for costly medications, and whose cost scores otherwise could have varied from year to year based on drug volumes. The 2018 Act also excludes separately billed items from determining whether a clinician meets the threshold of $90,000 of Medicare Part B billed claims required for participation in MIPS. Consequently, small practices that use many and/or expensive Part B drugs or other separately billed items may find that they are exempt from participation in MIPS.

- **Slower Implementation of Performance Threshold.** One feature of MIPS is a "performance threshold" that providers must exceed in order to avoid payment reductions. For 2019, the threshold would have been set at the average MIPS score—meaning that approximately half of all clinicians would fall below the threshold and would be subject to a Medicare Part B payment reduction. The 2018 Act gives CMS discretion to set gradually increasing point values for the performance threshold until 2022 when the threshold must be set at the average MIPS score, thereby limiting until at least 2022 the number of clinicians who will be exposed to

payment reductions. The threshold is currently set at 15 points for 2018. CMS has not yet determined what the gradual increase in point value will be for 2019 through 2021. Conversely, given that MIPS must be budget-neutral, this change also reduces the degree to which high-performing clinicians will receive significant positive payment adjustments.

- **Reduction in Base Physician Fee Schedule Update.** MACRA established annual 0.5% increases to the Medicare Part B physician fee schedule for each year through 2019. The 2018 Act reduced that increase for 2019 to 0.25%. This may be a result of the changes described above—MACRA, and MIPS specifically, funded annual fee schedule adjustments in part by reducing payments to low-performing clinicians. By backing away from features of MACRA that could have yielded reductions to low-performing physicians, the 2018 Act constrained Medicare's ability to fund general fee schedule increases established by MACRA.

The changes to MACRA appear to be well-received by stakeholders, reflecting Congressional response to concerns that had been raised about the complexity of MACRA generally, and of MIPS specifically. What remains to be seen, however, is if this marks the beginning of future efforts to re-shape and reduce the reach of MACRA programs. In 2017, the Trump administration made regulatory changes that reduced the number of clinicians required to participate in MIPS. Further, in early 2018, the Medicare Payment Advisory Commission, which advises Congress on Medicare policy, voted to eliminate MIPS altogether. Those changes and the changes adopted under the 2018 Act could portend further changes to MACRA in the years ahead.

Other Federal Health Care Program Changes

In addition to the changes to MACRA, the Act also revises some provisions of the ACA, extends coverage under the Child Health Insurance Program ("CHIP"), and provides other changes to health care programs and reimbursement. Specifically, the Act:

- **Accelerates the Reduction of the Medicare Part D "Donut Hole" Coverage Gap.** The Medicare Part D "donut hole" requires enrollees to pay a larger out-of-pocket share of any annual drug expenditures in excess of $3,750, until out-of-pocket expenses reach $5,000, at which point full coverage resumes. In 2011, Medicare Part D drug plans and pharmaceutical manufacturers started to share a part of enrollees' medication expenses incurred in the coverage gap. Beginning in 2019, the 2018 Act requires manufacturers to give larger prescription drug discounts (70%) to enrollees in the coverage gap, so that, when combined with Part D coverage (5%), enrollees' cost-sharing liability is 25%. Previously, enrollees' cost-sharing liability was scheduled to be reduced to 30% in 2019 and 25% in 2020. The 2018 Act also changes how much cost each party bears, materially increasing the burden on manufacturers and decreasing the burden on plans. To achieve the 25% enrollee cost share, the 2018 Act increases the planned manufacturer discount from 50% to 70% and decreases the Part D contribution from 25% to 5%.
- **Delays for Two Years Reductions in Reimbursement to Disproportionate Share Hospitals ("DSH").** The ACA anticipated reductions in DSH reimbursement, which would have been offset by increased reimbursement from growing rolls of insured individuals. Congress has delayed those cuts repeatedly, following determinations that increased reimbursement did not offset the anticipated cuts and the reality that states have not expanded Medicaid eligibility as originally contemplated by the ACA. The 2018 Act extends the delay for two years.
- **Expands Telehealth Coverage for Medicare Advantage Patients.** The 2018 Act allows Medicare Advantage plans to provide telehealth benefits, such as telemonitoring and medication therapy management, as a basic plan benefit, starting in 2020. This would permit enrollees to pay the same for telehealth consultations as they would for in-person visits, which would be a significant reduction from current cost-sharing obligations, in which telehealth services are treated as a costlier "supplemental" benefit.

- **Adds a Four-Year Funding Extension for the Children's Health Insurance Program ("CHIP").** Together with the January spending bill, which provided for six years of CHIP funding, CHIP now has funding for 10 years. The 2018 Act also extends funding for Community Health Centers by two years.
- **Eliminates the Independent Payment Advisory Board ("IPAB").** The ACA authorized the creation of the IPAB, which was intended to serve as a check on the rising costs of Medicare. The purpose of the IPAB was to recommend specific cost-savings measures to be implemented if Medicare spending was projected to grow faster than certain benchmarks. The IPAB was never utilized, and none of its 15 seats was ever filled, because spending growth has stayed below target growth rate. However, the IPAB's elimination now removes an advisory board that could have identified and recommended Medicare cost reductions should Medicare costs rise in the future.

Conclusion

The 2018 Act reduces the immediate impact of the MACRA programs by allowing CMS flexibility in setting performance score weights and thresholds. Together with regulatory changes from the Trump administration in 2017, this legislation marks meaningful changes to the still-new MACRA, presenting at least some question as to whether further changes to MACRA's complicated framework may be to come. If you would like to discuss the implications of the Act, please contact your usual Ropes & Gray attorney.