A Quick Guide:

Healthcare Provisions in the Bipartisan Budget Act of 2018

The Bipartisan Budget Act of 2018 (BBA18) was passed into law earlier this year and, while referred to as a "budget deal," it is also the most significant piece of healthcare legislation passed since 2016.

This quick guide highlights several of the key healthcare provisions changed and why it matters.

Healthcare Provisions in the Bipartisan Budget Act of 2018:

- Changes to MIPS and Physician Fee Schedule
- Medicare Extenders
- CHRONIC Care Act
- Repeal of the Independent Payment Advisory Board (IPAB)
- Hospice Care
- Rehabilitation Services

Merit-Based Incentive Payment System (MIPS) and Physician Fee Schedule

Overview of Changes	Why it matters:
The Merit-based Incentive Payment Systems (MIPS), one of the two physician Quality Payment programs established by MACRA, has been adjusted to provide CMS with flexibility to: • Reduce weighting of the cost domain • Slow the implementation of the performance threshold and other improvements Additionally, the Medicare Part B physician fee schedule was reduced to 0.25% for 2019.	Providing CMS with the ability to set gradually increasing point values for performance until 2022 will limit the number of physicians at risk for payment reductions in the short-term; however, this will also reduce increased payments for high performers.

Medicare Extenders

Overview of Changes	Why it matters:
Outpatient Therapy Caps • Permanent repeal of outpatient therapy caps beginning January 1, 2018 • An appropriate modifier indicating medical necessity on claims over $2,010 (the current exception threshold) is now required • Lowers the threshold for the targeted manual medical review process from $3,700 to $3,000	This provision effectively: • Ends 20 years of short-term extensions of a Part B therapy exceptions process • Ensures stability in patient access to medically necessary therapies • Delivers financial predictability to providers
Rural Home Health Add-On • Extends the 3% rural home health add-on for 2018 • Starting in 2019, it targets and gradually phases out rural add-on payments	The phased-down rural home health add-on provides: • Time for rural providers to prepare for payment adjustments • Retains an add-on payment for the most rural of providers for five years • Preserves access for beneficiaries for those five years
Home Health Reform Beginning January 1, 2020: • Budget-neutral reform will be mandated to the current home health payment system • The implementation of a 30-day episode for payment	By not implementing reforms for two years, providers have the time necessary to prepare for the new system; additionally, budget neutrality will retain current funding into the future system
Extends the Blended Site Neutral Rate • Prolongs the 50/50 hybrid freeze for two years for certain long-term acute care (LTAC) hospitals • Provides a temporary adjustment to site-neutral payment rates	The extension of the blended site-neutral rate provides more time for LTAC hospital professionals to adjust to patient criteria

CHRONIC Care Act

Overview of Changes	Why it matters:
The CHRONIC Care Act includes key provisions for beneficiaries living with multiple chronic conditions. This includes, but is not limited to: • Extension and expansion of the Independence at Home demonstration • Allowances for providers to utilize telehealth for certain patients • Beginning in 2020, it allows Medicare Advantage plans to offer new supplemental benefits to chronically ill enrollees	The CHRONIC Care Act serves as an important first step in legislating solutions for patients living with multiple chronic conditions; this act sets the foundation for more targeted reforms addressing care management for chronically ill patients in post-acute and in-home settings

Repeal of Independent Payment Advisory Board (IPAB)

Overview of Changes	Why it matters:
The Independent Payment Advisory Board (IPAB), a budgetary tool to make mandatory Medicare cuts, with limited opportunity for Congressional input, when Medicare spending exceeded per-capita growth targets, was repealed	Elimination of the IPAB: • Creates more predictability in reimbursements for Medicare practitioners • Returns authority for any Medicare cuts to the U.S. Congress, making "one-off" cuts much less likely

Hospice Care

Overview of Changes	Why it matters:
Hospital Transfer Policy • Creates a hospital transfer policy for early discharges to hospice care • When the patient is discharged and the length of stay is shorter than the geographic mean length of stay for the assigned MS-DRG, the transferring hospital will be paid a per diem rate rather than the usual MS-DRG	While such policies exist for other post-acute settings, because this provision will reimburse providers on a per diem rate, this may have a negative impact on transferring patients to hospice care at the most appropriate time
PAs and NPs • Physician assistants and nurse practitioners can act as an attending physician in establishing and reviewing a hospice patient's plan of care and other purposes • However, only a physician can certify and recertify an individual as having a terminal diagnosis in order to qualify for hospice care	This move represents an important first step in addressing the significant physician shortage in hospice care and substantiates the important and growing role of PAs and NPs; further, this should help ensure that patients have access to hospice care services as soon as they need them

Rehabilitation Services

Overview of Changes	Why it matters:
Expansion of Supervisory Roles Beginning in 2024, physician assistants, nurse practitioners and clinical nurse specialists are allowed to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs	This expansion of the types and number of clinicians who can supervise these patient types will improve patient access to vital services
Reduces Therapy Assistant Rate Beginning in 2022, pay for outpatient physical and occupational therapy services furnished by a therapy assistant will be reduced to 85 percent of the rate of a therapist	This provision is similar to the current approach to payment for physician assistants and nurse practitioners, as they are paid 85% of what physicians are paid; however, this will require providers of outpatient therapy to adjust to new payment realities and reconsider staff resources

For a more in-depth review of all healthcare provisions in the Bipartisan Budget Act of 2018, please visit **https://www.reedsmith.com/en/perspectives/2018/02/new-medicare-medicaid-other-health-policy-payment-provisions-adopted**

How Kindred Can Help

As the nation's leading specialty hospital and rehabilitation provider, Kindred Healthcare prioritizes superior clinical outcomes for difficult to treat patients, positive patient experience, and strong partnerships to deliver the right care at the right time. Over the past several years, Kindred Healthcare has transformed its capabilities to meet the health, recovery and wellness needs of the most chronically and critically ill Americans, which has included the testing of new payment and delivery models.

The Bipartisan Budget Act of 2018 included several initiatives including prioritization of care solutions for chronically ill patients, investment in telehealth services, and the extension of key Medicare policies which create a stronger platform to enhance patient-centered care. Legislative changes such as these will lead to greater innovation and allow Kindred Healthcare to leverage our hands-on experiences from across the country to educate policymakers and positively shape new healthcare laws.

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