On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (“BBA”). Among the most notable changes that will occur with the enactment of the BBA is the inclusion of certain provisions taken from the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (“CHRONIC”) Care Act of 2017 bill (S.870) which the Senate passed in September 2017. Among other things, the CHRONIC Care provisions will have the effect of redefining new criteria for special-needs plans (“SNPs”), in particular the special-needs Medicare Advantage (“MA”) plans for chronically ill enrollees. The CHRONIC Care provisions also will expand the integration and coverage under Medicare for certain telehealth-based chronic care services.

Impact on MA Special Needs and Other MA Plans

The BBA includes provisions taken from the CHRONIC Care Act that largely affect MA SNPs, though other types of MA plans may also be affected by the enacted changes.

The critical issue Congress finally settled through the enactment of the BBA is the long-term status of the MA SNP Program (the “Program”). Congress created the Program through the Medicare Modernization Act of 2003 (enacted Dec. 8, 2004). However, the Program was time limited, with a scheduled end date of December 2008. The Program has since been extended a total of 7 times, with Congress generally pushing out the Program’s end date by a year or two but never giving stakeholders a clear signal of support for the Program, leaving many stakeholders hesitant in making large investments in a program that was scheduled to terminate.[1]

The amendments made by the BBA have provided not only a more secure future to encourage plan sponsors and other stakeholders to further invest in the Program, but have also made changes to strengthen these programs. With respect to those SNPs targeting the dual eligible population (“Dual SNPs”), statutory changes provide for: increasing integration through use of mechanisms to better coordinate contact with and information dissemination to State partners; requiring the Secretary to develop a unified grievances and appeals process for Dual SNPs to implement by 2021; and imposing more stringent standards to demonstrate integration. With respect to those SNPs focused
on serving the chronically ill ("Chronic SNPs"), the BBA broadens the definition of beneficiaries who qualify to enroll in a Chronic SNP, imposes more stringent care management standards, and authorizes Chronic SNPs to provide certain Supplemental Benefits. The BBA further amends the Social Security Act to authorize the Secretary to require quality reporting at the plan level for SNPs, and, subsequently, for all MA plan offerings.

**Impact on Accountable Care Organizations**

The BBA makes several statutory changes impacting Accountable Care Organizations ("ACOs") and beneficiary participation in such entities. Specifically, under the terms of the Act, fee-for-service ("FFS") beneficiaries will be able to prospectively and voluntarily select an ACO-participating professional as their primary care provider and for purposes of being assigned to that ACO. The BBA further authorizes ACOs to provide incentive payments to encourage fee-for-service beneficiaries to obtain medically necessary primary care services.

**Expansion of Medicare FFS Telehealth Coverage for Chronic Care Services**

Additionally, the BBA includes certain provisions taken from the CHRONIC Care Act that will provide a needed expansion of Medicare FFS coverage for certain telehealth-based chronic care services. The BBA preserves many of the telehealth-focused aspects of the original 2017 bill equivalent and, seemingly, reflects a commitment by the federal government to improving access to telehealth services for qualified Medicare beneficiaries and further integrating these services into the U.S. health care system. For example, with the enactment of the BBA, Medicare coverage of telehealth services will be expanded to include services provided at home for beneficiaries dealing with end-stage renal disease ("ESRD") or those being treated by practitioners participating in Accountable Care Organizations ("ACOs"). Additionally, with the enactment of the BBA, some of the geographic requirements traditionally required by Medicare’s coverage rules for telehealth services (e.g., originating sites, rural health professional shortage areas, counties outside Metropolitan Statistical Areas) will be lifted if such telehealth services are rendered to beneficiaries with ESRD, or who are being treated by ACO practitioners, or who are being diagnosed, evaluated, or treated for symptoms of an acute stroke. There are some important caveats to these changes in the coverage rules. For example, for ESRD beneficiaries who utilize telehealth services from their homes, an in-person clinical assessment will be required for such beneficiaries every month for the first 3 months and then once every 3 months thereafter. Likewise, payments will not be made for any telehealth services rendered by ACO practitioners to beneficiaries in their homes if such services typically are furnished in inpatient settings (e.g., hospitals).

As part of increasing benefits offered to special needs MA plan enrollees (as discussed above), the enactment of the BBA also will allow MA plans to offer more telehealth services to its enrollees, including services provided through supplemental health care benefits, starting in the year 2020. However, this provision requires that the same types of items and services an MA plans offers to its enrollees via telehealth are also offered to enrollees in-person. CMS is required to solicit public comments regarding this particular provision by November 30, 2018.

With the BBA establishing a long-term MA SNP Program, we are more likely to see increased investment into the Program by stakeholders and plan sponsors, thus growing and strengthening the Program. But, as explained above, the BBA also introduces several amendments that will certainly affect Dual and Chronic SNP standards, benefits, and coordination of care. Although CMS has not formally solicited public comments regarding implementation of the referenced changes to SNP requirements, stakeholders and plan sponsors may want to consider the impact these changes may
have on them and their industry and submit comments and input to help CMS in developing its proposed regulations.

For telehealth advocates, the inclusion of so many meaningful provisions in the BBA signals a newly energized willingness on the part of policymakers to work to expand use of telehealth services for Medicare beneficiaries, even in an environment where there are financial incentives for providers and health plans to restrain costs. Although lawmakers have historically resisted expanding these types of services in a FFS context, the belief being that doing so would add to (and not replace) services already otherwise being delivered, the enactment of the BBA signals strong potential for change in this regard. As telehealth integration into various Federal programs increases, the enactment of the BBA being a critical step in this process, stakeholders and plan sponsors may want to consider the various implementation strategies by which telehealth items and services will be offered since each program carries its own set of standards and requirements.


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